Chemist&Druggist
The News weekly for Pharmacy

C&D

6 October 2001

OTC abuses highlighted in Scottish survey

Blears hints at prescribing pilot roll out

SSL sells its continence care for £80m

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NEW

clotrimazo

Product Information for Canesten® Complete Cream. Presentation Canesten® Complete Cream A prefilled applicator (5g) of cream containing clotrimazole 10% w/w, plus a 10g tube of Canesten Th Cream containing clotrimazole 2% w/w. **Indications:** Treatment of candidal vaginitis and associated candidal vulvitis. **Dosage and Administration Adults:** Insert the contents of the filled applicator intravaginally and apply the cream to the vulva and surrounding area two or three times daily and rub in gently. **Children:** Paediatric usage is not recommended. **Contra-indications:** Hypersensitivit clotrimazole. **Warnings and Precautions:** A physician should be consulted if this is the first time the patient has experienced symptoms of candidal vaginitis or if any of the following are applicable: more t two infections of candidal vaginitis in the last six months; previous history of or exposure to partner with a sexually transmitted disease; pregnancy or suspected pregnancy; aged under 16 or over 60 years; kn hypersensitivity to imidazoles or other vaginal antifungal products. Medical advice should be sought if the patient has any of the following symptoms: irregular vaginal bleeding; abnormal vaginal bleeding blood-stained discharge; vulval or vaginal ulcers, blisters or sores; lower abdominal pain or dysuria; any adverse events such as redness, irritation or swelling associated with the treatment; fever or chills; na or vomiting; diarrhoea; foul smelling vaginal discharge. If no improvement in symptoms is seen after seven days, the patient should consult their doctor. This product may damage latex contraceptives there patients should use alternative precautions for at least five days after using it. **Side-effects:** Rarely, local mild burning or irritation immediately after use. Hypersensitivity reactions may occur. **Use in Pregna** Only when considered necessary by a physician. Take extra care when using the applicator to prevent the possibility of mechanical trauma. **Cost:** £9.89 **MA Number:** PL 0010/0136 and PL 0010/0077. **MA Hol** Bayer plc, Consumer Care Division, Newbury, Berkshire RG14 1JA. **Legal Category:** P. **Date of Preparation:** May 2001.

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This Week

Pharmacy Update

Regulars

Features

OTC misusers total five a week

The average pharmacy encounters between five and six patients a week who misuse OTC medicines, a survey has shown.

Forty-six products were involved, particularly sleeping aids, laxatives, analgesics, cough linctuses and other products containing pseudoephedrine, caffeine, codeine and dextromethorphan.

Lynn MacFadyen and colleagues at the University of Strathclyde and Lanarkshire Health Board studied 86 pharmacies in Scotland to examine their response to OTC medicine misuse. All had experience of such misuse, but only 31 per cent had frequent problems. Most (58 per cent) had problems occasionally.

Female pharmacists were more likely to advise suspected misusers, particularly in difficult situations, such as patients with eating disorders or drug/alcohol problems.

Writing in the *Journal of the Royal Society for the Promotion of Health*, the authors say their research has shown the need for greater consistency in the management of OTC medicine misuse and the development of nationally-agreed guidelines for pharmacies.

Pharmacists felt they needed more training and were interested in early warning systems for alerting each other to suspected misuse. A fifth of those studied already shared information about patients who might be misusing medicines.

All pharmacists had been alerted to misuse by patients asking for products too frequently, but nearly half referrred to a "gut reaction".

Nytol was reported as the most frequently abused product, with 79 per cent saying it was subjected to "a lot/fair amount of misuse". But the definition of misuse was not unequivocal, the authors say.

Some pharmacists interpret the prolonged use of sleeping aids as problematic, while others believe it improves the quality of life.

Laxatives were the next highest on the list of drugs misused (58 per cent).

Most pharmacists advised patients to see their GP.

For more information:

J Roy Soc Health 121(3), 185-192
Tel: 020 7630 0121.

Pharmacists not supporting mentally ill

Pharmacists are not supporting older people with mental health problems, according to a report.

Medicines and Good Mental Health in Later Life says that older people with mental health problems living at home are "at risk of mismanaging their own, often complex medication". It says there are poor support links between community pharmacists and mental health teams or social services. Projects that appear to provide home pharmacy support are mainly on a short term basis.

The report, written by Diane Harris, a research pharmacist from South Derbyshire, was published by the Mental Health Foundation this week.

The Foundation recommends that further work is done to promote domiciliary visits and to find out how patients would like such services to be developed. If more pilot projects were established to provide evidence of the costs and benefits of such services this could be used to justify long-term funding being made widely available for services across the UK.

For more information:

www.mentalhealth.org.uk
Tel: 020 7535 7441.

NORTHERN IRELAND

Maguire bows out of NICPPET

The shortage of community pharmacists has led to Dr Terry Maguire standing down at the end of October as director of the Northern Ireland Centre for Pharmacy Postgraduate Education and Training.

Dr Maguire owns two community pharmacies in Belfast and has been unable to recruit pharmacist managers to look after the shops while he oversees the NICPPET. The centre is based within the School of Pharmacy at the Queen's University in Belfast.

"I am bitterly disappointed that I will not be around when the NICPPET's new resource centre opens," Dr Maguire said this week. "It was a hard decision to make but my businesses have been suffering. Running on locums is a dangerous situation to get into."

Although the NICPPET is funded by the Department of Health, it is administered by the University. The post of director will be advertised towards the end of this month.

- There was a 7.5 per cent increase last year in direct contact hours for pharmacists taking part in live courses provided by NICPPET. However, the Centre believes a plateau has been reached in live course provision.

Its annual report says the key to good attendance is not the number of courses offered but their relevance to working pharmacists.

The uptake in live training was over 8,500 hours and the Centre provided 15,176 contact hours of distance learning. About 78 per ent of N Ireland phamacists undertook training last year.

Questiontime

Do you support the continuation of the existing control of entry regulations for NHS community pharmacy services? *(see p5)*

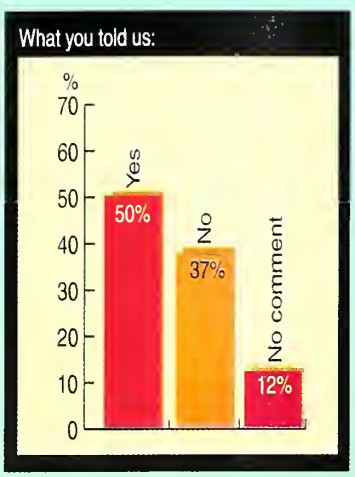
- Yes - No - Not sure

You can record your vote on our website: *www.dotpharmacy.com*. On the home page you will find a link to the Question Time page. Select your answer and then click on the "vote" box. Your answer is automatically collated.

You have until 12.00 noon on October 9 to cast your vote. We will publish the result in *C&D*, October 13.

Last week we asked you:

Do you think the shortage of GPs and nurses in primary care offers a real opportunity for pharmacists to improve their representation on PCTs (and their equivalents in N Ireland and Scotland)?



Learn more about nasal congestion

An accredited tutorial on nasal congestion can be found on pages 33-34 of this issue.

This is the eighteenth *C&D* tutorial and is sponsored by Novartis Consumer Health. It provides one hour's postgraduate education towards the College of Pharmacy Practice's continuing education requirement.

Lord Hunt (left), Under-Secretary of State for Health, opened AstraZeneca's new £45 million pharmaceutical development facility at its site in Charnwood, Leicestershire. The facility is part of a £250m investment in scientific facilities there and will provide medicines for clinical trials and develop manufacturing processes. Lord Hunt is pictured with Dr Tom McKillop, chief executive, AstraZeneca, in a tablet development area of the new building

OFT to investigate control of entry regulations

The Office of Fair Trading has announced a study into retail pharmacy services, and particularly whether consumers are best served by the control of entry regulations.

Announcing the inquiry on Wednesday, the OFT said: "Restrictions on where chemists can open potentially have an effect on competition and not only in dispensing prescriptions."

It will review the system "to see how the present restrictions affect competition and consumers and whether there are alternative ways of achieving the public interest objectives behind the present arrangements".

An OFT spokesman said the barriers to entry within pharmacy raised questions about whether these restricted supplies of pharmacy products, and pushed up prices.

The OFT study will last six to 12 months, and will take evidence from interested parties, including pharmacies and consumers. Its report will be publicly available when completed.

OFT director general John Vickers says this is an exploratory study, not an inquisition. "No one is in the dock, though if a study reveals the need for further action under our enforcement powers, we will act accordingly."

Having completed its report, the OFT has several options:

- refer the matter to the Competition Commission
- recommend that the Government considers changes in the laws and regulations
- do nothing – assuming the report's findings do not raise any competition issues.

Pharmacists who want to contribute to the study can call the OFT on: 0845 7224499.

Pharmacy bodies were caught completely by surprise by the news of the OFT inquiry.

The Pharmaceutical Services Negotiating Committee pointed out that: "The control of entry regulations were introduced to secure value for money for the NHS and the public who, as taxpayers, pay for the services, and to secure ready access to pharmacies for customers."

It added: "For contractors faced with the uncertainties of radical change in NHS structures, new roles, workload and manpower pressures and concerns about future remuneration, the news is unsettling and threatening."

However, PSNC says that it will "assist the OFT in understanding the issues, including the possible impact on patient services by creating instability in the market".

John D'Arcy, chief executive of the National Pharmaceutical Association, said the control of entry regulations had worked well for consumers. They had been effective in creating a more rational distribution of outlets which gave easy access to pharmacy services from where people lived and worked.

He added that the regulations had been vital to pharmacy businesses in providing a relatively stable platform from which they could develop and enhance NHS pharmaceutical services for the benefit of patients.

News of the OFT inquiry was welcomed by Superdrug. Asda, which had been one of the drivers behind the OFT's action on Resale Price Maintenance, said it was pleased that the issue was being investigated.

South Asian donor campaign

Health minister Jacqui Smith has launched the third phase of the South Asian organ donation campaign, which includes a TV and press campaign to raise awareness of the growing numbers of Asian patients currently waiting for transplants. South Asians will also be encouraged to become organ donors. Copies of the *Organ Donation and the Asian Community* leaflet are available by calling: 0845 6060400. The leaflets are available in English, Hindi, Gujarati, Urdu, Bengali and Punjabi.

BPC 2002

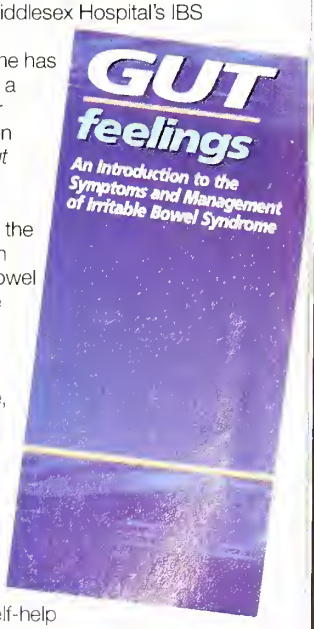
The British Pharmaceutical Conference 2002 will be in Manchester on September 23-25. For more information, contact Health Links, the Royal Pharmaceutical Society's conference organiser on: 0121 248 3399.

NCSO endorsements

The Department of Health and the National Assembly for Wales have agreed to allow NCSO (no cheaper stock obtainable) endorsements for Co-careldopa tablets BP 25/100 for October prescriptions.

New IBS leaflet

Central Middlesex Hospital's IBS Research Programme has produced a consumer information leaflet, *Gut Feelings*, which describes the three main irritable bowel syndrome variants: spastic colon syndrome, functional diarrhoea and midgut motility disorder, and suggests simple, self-help treatments. A sample copy and order form for bulk quantities are available free by sending a stamped, self-addressed envelope (one third A4 size) to: OTC IBS Leaflet, 32 Cannon Street, St Albans, AL3 5JS. The extra leaflets are also free, but you have to pay for the postal charges.



First national mouth cancer week set

The Royal Pharmaceutical Society is among 26 professional healthcare organisations backing the first ever national mouth cancer awareness week, which runs on November 11-17. Pharmacies and other healthcare specialists could help by identifying patients most at risk from the disease. Any pharmacist who wants to support this initiative can get an information pack by e-mailing: *admin@thescopegroup.com*.

Keep warm this winter

The Department of Health has launched its *Keep Warm, Keep Well* campaign for this winter.

Run in conjunction with other organisations and Government departments, the campaign aims to provide advice on how to stay healthy during the winter along with information about financial and practical help that is available.

Information is available on *www.doh.gov.uk.kwkw*, or from: *Keep Warm, Keep Well*, PO Box 777, London SE1 6XH

Boots launches incident handbook

Boots The Chemists has launched a handbook to help pharmacists reduce dispensing errors. It builds on Boots' existing reporting system.

The *Dispensing Incident Management Handbook* provides a process for pharmacists to:

- take action to prevent future errors
- analyse errors to understand the contributory factors
- disseminate insights and best practice
- produce an audit trail to show how risks are being managed.

EMEA agrees on Pill risk

The risk of venous thromboembolism is higher with "third generation" oral contraceptives than with earlier formulations, says the European Medicines Evaluation Agency.

The EMEA's conclusions match those reached by the Medicines Control Agency in 1999. The MCA has reissued the Department of Health's guidance on the use of the third generation contraceptives, but warns that the findings are not new. The information on the risk of VTE has already been added to prescribing material and patient information leaflets, says the MCA.

POLITICS

Minister backs prescribing pilots

Health minister Hazel Blears will be pushing to extend the Tyne & Wear Health Action Zone pharmacy prescribing pilot across the country.

Speaking on Monday at a fringe meeting at the Labour Party conference, Ms Blears said she had been impressed by the results when she visited Tyne & Wear and saw no reason why the scheme could not be rolled out nationwide.

The pilot began last November and involved three GP surgeries and 13 pharmacies. The GPs gave patients with selected mild ailments two tokens which they could exchange for an OTC remedy recommended by a pharmacist.

Each pharmacy received a £250 honorium and was reimbursed for the cost of the medicines. They also received a £1.50 transaction fee per token.

A review of the pilot found that the average cost of its prescriptions was £5.58, around half that of an average FP10, and patients appreciated how quickly they were seen and treated (*C&D June 30, p5*).

The fringe meeting: *Life Chance or Lifestyle – can the Government Alone Reduce Health Irregularities?* – was sponsored by Boots The Chemists.

PRACTICE

MP calls for NHS services overhaul

Dr Howard Stoate, chairman of the All Party Pharmacy Group, has called for a radical overhaul in the way the NHS delivers its services because "the traditional solution to NHS services is running into the buffers".

Dr Stoate wants to see more collaboration with pharmacists over medicines management, concordance and prescribing.

"At least £300 million worth of medicines are wasted every year," he said. "If a pharmacist received a fee for every person they took on in a medicines management scheme, the Government would still save money."

Dr Stoate cited the examples of the pharmacy prescribing pilot in Tyne & Wear and the emergency hormonal contraception pilot in Newcastle as excellent examples of how pharmacists could collaborate more effectively with GPs. He was speaking at a fringe meeting – *Prescription Charges and Primary Care – Who Pays?* – arranged by the main pharmacy organisations, at the Labour Party Conference in Brighton.

Sandra Gidley, the Liberal Democrat front bench spokesperson on health, said she would like to see a fairer system of prescription charges.

A Mori poll revealed that 750,000 people in England and Wales had failed to pick up prescriptions because of the cost involved. "I believe health services should be free at the point of delivery and there should be equality of access," she said.

PSNC's Mike King, left, and Roger Odd, of the RPSGB, in conversation with Cherie Blair at the Labour Party Conference in Brighton

EUROPE

EU agrees on vitamin levels

The European Council of Ministers has reached political agreement on some controversial aspects of the draft food supplements directive.

A meeting last week agreed that the upper safe levels of vitamins and minerals should be based on a scientific risk assessment.

Many member states had been pushing for upper safe levels to be based on RDAs. The UK supported the compromise agreement as the best achievable deal. It allows, but does not require, the limits to be based purely on safety.

The European Commission will set individual maximum levels, taking into account the advice of the EU Scientific Committee on Foodstuffs and the views of member states. The UK view will be based on the FSA's expert group on vitamins and minerals' scientific risk assessment, due to be completed this month and published in November.

Last week's meeting also agreed to a seven-year transition period for manufacturers to produce scientific dossiers in support of substances not included in the directive's positive lists.

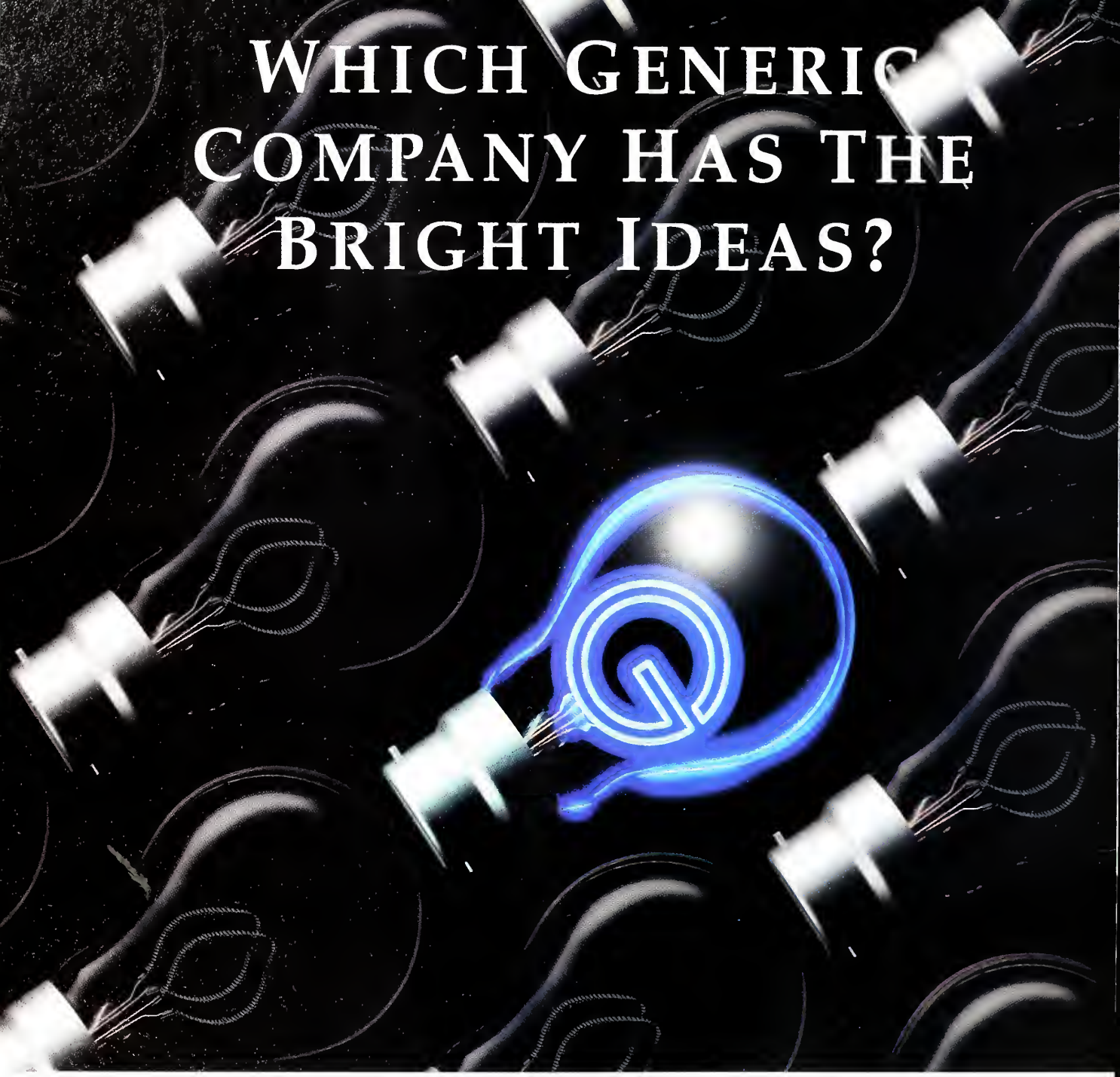
The Association of the European Self-medication Industry (AESGP) believes this is a reasonable time frame in which to expand the lists. The directive now goes for a second reading in the European Parliament.

DOUBLE WWHAM-Y

New, pharmacy only, double strength (10% ibuprofen) gel.

Product information. Nurofen Gel Maximum Strength: Gel for topical administration containing ibuprofen 10%w/w. **Indications:** For the relief of pain and inflammation associated with backache, non-serious arthritic conditions, rheumatic and muscular pain, sprains, strains, sports injuries and neuralgia. **Dosage:** Adults, the elderly and children over 14 years: Squeeze 2 to 5cm of the gel (50 to 125mg ibuprofen) from the tube and lightly rub into the affected area until absorbed. The maximum number of applications of 5cm gel in any 24 hours is four. Wash hands after each application. The dose should not be repeated more frequently than every four hours. Do not exceed the stated dose. Review treatment after 2 weeks, especially if the symptoms worsen or persist. Children under 14 years: Do not use on children under 14 years of age except on the advice of a doctor. **Precautions and Warnings:** Apply with gentle massage only. Avoid contact with eyes, mucous membranes and inflamed or broken skin. Discontinue if rash develops. Hands should be washed immediately after use. Not for use with occlusive dressings. The label will state: Do not exceed the stated dose. Keep out of the reach of children. For external use only. If symptoms persist consult your doctor or pharmacist. Do not use if you are allergic to ibuprofen or any of the ingredients, aspirin or any other painkillers. Consult your doctor before use if you are taking aspirin or any other pain relieving medication, you are pregnant. Not recommended for children under 14 years. **Side Effects:** Hypersensitivity reactions have been reported following treatment with ibuprofen. These may consist of a) non-specific allergic reaction and anaphylaxis. b) respiratory tract reactivity comprising of asthma, aggravated asthma, bronchospasm or dyspnoea, or c) assorted skin disorders, including rashes of various types, pruritis, urticaria, purpura, angiodema and less commonly, bullous dermatoses (including epidermal necrolysis and erythema multiforme). Gastro-intestinal: abdominal pain, dyspepsia. **Product Licence Number:** PL 10972/0082. **Licence Holder:** Goldshield Group PLC (trading style: Goldshield Pharmaceuticals), NLA Tower, 12-16 Addiscombe Road, Croydon CR0 0XT. **Legal Category:** P. **Price:** MRRP £5.25. **Date of preparation:** June 2001. Distributed by Crookes Healthcare Limited, Nottingham, NG2 3AA. NU295.

CROOKES HEALTHCARE



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IT

Full-scale ETP pilots delayed

Trial transmissions for the electronic transfer of prescriptions (ETP) between the Prescription Pricing Authority and the three participating consortia are likely to take place in the next few weeks.

However, the full-scale pilots are unlikely to start before the end of November due to delays in delivering the GP system. As the three consortia involved are using the same GP software supplier, Emys, the most likely outcome is a synchronised start of all three pilots.

The PPA has developed a single system to cope with the three different inputs it will receive from the pilot schemes.

"There are technical issues involved in having three unique message handlers, but when one system is rolled out nationally, there will be a need for only one," said Douglas Ball, IT director, PPA.

Ian Shepherd, head of Information at the Royal Pharmaceutical Society (RPSGB), said one of the main questions to be answered by the pilots was whether NHSNet in its current form is equipped to cope with the vast number of transactions, especially under the relay system.

"NHSNet may well have to be updated, especially as it currently does not carry out any time-sensitive transactions," he said, adding that prescriptions may have to be accessible in the pharmacy within minutes.

It has also emerged that users of UniChem's Mediphase system, which has been updated over recent months, may not be able to participate in one of the pilots, due to technical incompatibilities. SchlumbergerSema, the consortium which includes Boots The Chemists and National Co-operative Chemist, does not use a plug-in facility and therefore requires the pharmacy system to be ETP-enabled. The same problem does not arise with the other two pilots.

James McVicar, project director for the Peterborough-based Flexiscript pilot, said he was currently talking to all Mediphase users in an attempt to overcome the problem. UniChem would not comment on why ETP compatibility had not been included in the newly developed Mediphase system.

Separately, *C&D* has learnt that Tosh Mondal has left Enigma Health, the company owning the Mediphase system, where he was an executive director.

Around 25 pharmacies are said to have signed up to the Flexiscript pilot so far, with a roughly equal split between independent pharmacies and pharmacy chains. Flexiscript expects to install the updated AAH LinkScript2 software in participating pharmacies soon.

Meanwhile, TranSript, the wholesaler-led consortium, said it had changed the area of its pilot, which is now taking place in East Hampshire.

Thirty pharmacies are expected to take part.

MEDICINES

Drug abuse prompts pilot project

A pilot project to identify customers abusing over the counter medicines has been tested in two community pharmacies.

The pharmacists had to identify patients who were apparently misusing or abusing OTC products and follow this up with the provision of advice and counselling.

The project was developed by the School of Pharmacy at Queen's University Belfast, and sponsored by the Proprietary Association of Great Britain.

There are plans to extend the project to more pharmacies in the future. A research psychologist will train the participating pharmacists in motivational interviewing techniques and specialised communication skills.

Professor James McElnay, of Queen's University, said work is in progress to increase awareness of the safe and effective use of OTC medicines amongst pharmacy clients.

Simply the best: Mary McLaney, dispensing assistant, left, Jenny Harvey, pharmacist manager, centre, and Libka Smrckova of Barron Pharmacy

PRACTICE

Awareness week in Glasgow

Pharmacies in Glasgow took part in a week-long campaign to raise awareness of the services they provide to the local community.

Pharmacists received information packs containing window banners, posters, mugs and T-shirts and were encouraged to organise events in local schools, nurseries and shopping centres.

Each pharmacy was invited to submit a photograph of their campaign display with a short report on their local initiatives.

The Barron Pharmacy, Clydebank, was judged the best entry and received a cheque for £200, presented by Alison Strath, chairman of the Royal Pharmaceutical Society in Scotland, during the British Pharmaceutical Conference.

The campaign was organised by Liz Grant, promotion pharmacist for the Greater Glasgow Health Board.

SPF calls for access to more data

The Scottish Pharmaceutical Federation is highlighting the need for pharmacists to have more access to patient data.

In its response to the Scottish Executive's consultation, *Protecting Patient Confidentiality*, the SPF says that community pharmacists currently lack data that may help them to improve patient care. It is also concerned that the consultation paper does not recognise that community pharmacists are among those who require access to information.

In conjunction with its sister body, the National Pharmaceutical Association, the SPF is drafting advice for its members to support them when informing patients of how information relating to them is recorded and used.

Three more health reports due

Further research into community pharmacists' role in health improvement will be published before the end of the year.

Following the launch at the British Pharmaceutical Conference of a literature review *(C&D, September 29, p6)* there will be three more reports, said Professor Alison Blenkinsopp at BPC.

Items to be covered include "grey literature" and two case studies.

For more information:
www.rpsgb.org.uk/patientcare
E-mail: *phs@rpsgb.org.uk.*

New website for BPSA in 60th year

The British Pharmaceutical Student's Association has celebrated the start of its 60th anniversary year with the relaunch of its website. The site now provides details about education, careers advice, BPSA events and other services.

A secure access area also contains resources such as documents and databases. A key event in the Diamond Jubilee year will be the annual conference and ball. The conference will be held at the University of Strathclyde School of Pharmacy, Glasgow, from March 22 to 30, 2002.

Potential sponsors are invited to contact Joyce Kearney at Chandon, 6 Shibden Hall Croft, Halifax HX3 9XF. Tel: 01422 201201.

For more information:
www.bpsa.com.

Boots reduces online photographic services

Boots The Chemists is discontinuing some of its online photographic services at *bootsphoto.com*, after the demand and revenue failed to meet initial expectations.

The services affected are the "upload" and "storage" facilities, which allowed customers to load photographs onto the internet, to be stored or e-mailed.The site will continue to provide features and tips on photography.

Bootsphoto.com, which was launched only 12 months ago at an estimated cost of £9 million, is expected to record operating losses of £7.3m for the first six months of the current financial year. Winding down the online services could cost the company as much as £10m, largely due to contractual obligations.

The company intends to relaunch the site early in 2002 with a range of digital services such as picture-editing, printing and e-mail.

National Minimum Wage increases

With effect from October 1 the National Minimum Wage has been raised to £4.10 for workers aged 22 and over and to £3.50 for workers between 18 and 21 years of age.

Pharmacy sales slow in September

Pharmacy sales fell to a three-month low in September, according to the latest *Distributive Trade Survey* published by the Confederation of British Industry (CBI).

Fifty-eight per cent of the pharmacists questioned said sales and orders had been higher than a year ago and 29 per cent reported a fall. The remainder (13 per cent) reported static sales.

The balance of plus 29 is below last month's plus 51 and July's plus 44.

Napp appeal gets underway

Napp Pharmaceuticals' appeal against a £3.2 million fine imposed by the Office of Fair Trading (OFT) started at the Appeals Tribunal. The OFT had fined Napp because of its different pricing policies in hospital and community pharmacies (see *C&D April 7, p24*). Following a four day hearing, the judge. Christopher Bellamy QC, said he would issue a ruling by the end of November.

Nucare refit for second pharmacy

Aldermans Pharmacy in Palmers Green, London, owned by Nucare member Atul Shah, is the second pharmacy to be refitted with the buying group's new branding and fascia.

"Nucare's approach demonstrates clearly how it is proving itself to be the champion and guardian of independent pharmacy," said Mr Shah. Nucare revealed its first rebranded pharmacy in June 2001.

BUSINESS

SSL continence business is sold

SSL International (SSL) has sold its continence care business to Danish healthcare company Coloplast A/S for £80 million.

Brian Buchan, chief executive of SSL, said: "SSL continence care is a sound and profitable business. However, we recognise that expansion outside the UK would not be possible without a significant acquisition... we have concluded that a disposal to Coloplast... is in the best interests of SSL and of the business itself."

The deal covers the inventory, goodwill, patents and trademarks attached to the business, as well as the catheter manufacturing equipment of SSL's Oldham site.

Also included in the sale are six ThackrayCare dispensing centres, and ThackrayCare Nursing Services, a team of specialist urology nurses providing a dispensing and advice service for continence products in the patient's home environment.

However, SSL's Scunthrope site, which manufactures around 60 per cent of the company's continence products, will not now be part of the deal, after a fire destroyed the facility on September 26.

Reacting to media speculation which suggested that SSL had been forced to accept a reduced selling price, a spokeswoman for the company said that "the deal was done at £80 million and we feel that's a good price".

She pointed out that Coloplast's main interest had been in the brand names and the marketing and distribution expertise, which had been sold.

SSL will retain the property in Scunthorpe pending an insurance claim.

SURVEY

Lloyds ahead on growth

Lloydspharmacy recorded the largest sales growth among retail and wholesale chemists in the year 1999/2000, according to a business ratio report published by The Prospect Shop.

Lloyds' sales growth was 93 per cent, mainly due to acquisitions, but increased costs associated with these reduced the pre-tax profit margin to minus 3.1 per cent.

Boots The Chemists managed only 5 per cent sales growth for the same period, but had the largest sales turnover, £3.9 billion, and the highest pre-tax profit margin of 8.1 per cent.

Alliance Unichem, which owns the Moss pharmacy chain, was the largest wholesaler, with a sales turnover of £6bn, compared to AAH Pharmaceuticals, which had a sales turnover of £2.3bn.

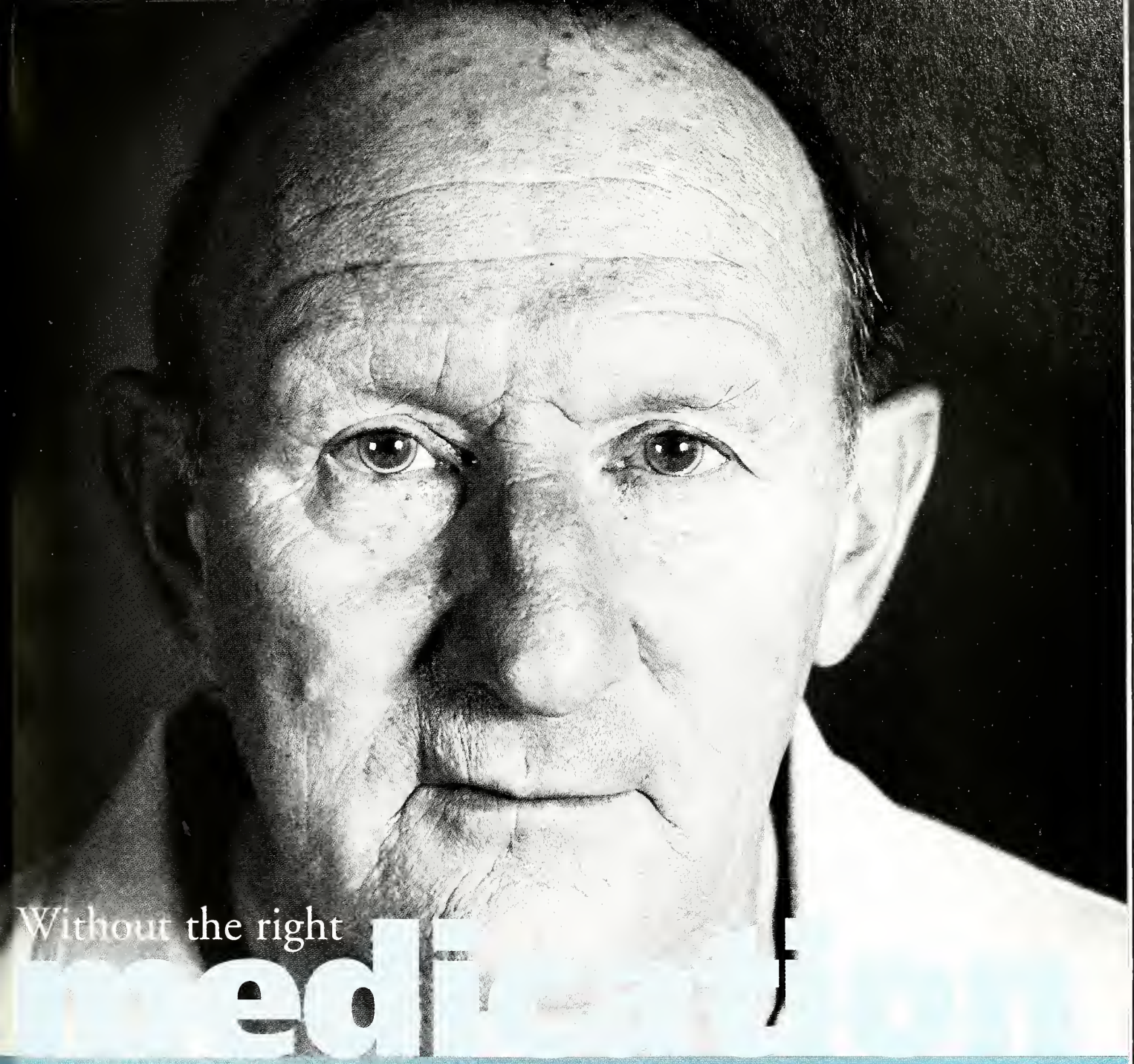
The report concluded that despite rising sales and profits, profitability ratios, such as return on capital and investment, improved only slightly and efficiency ratios had deteriorated.

The future still looks promising for the sector. Over the last three full acounting years, 1997-2000, total sales by leading retail and wholesale chemists rose on average by 31.3 per cent, and total profits by 80.5 per cent.

The report is published annually and provides data and analysis allowing comparison of over 100 companies in the industry.

For more information:

Price: £275 plus £4.95 p&p
The Prospect shop
Tel: 020 8481 8720.



Without the right

Colin could die. He's not the only one dependent on our pharmacists.

When Colin was admitted to A&E he was immediately diagnosed with deep vein thrombosis. A life threatening condition, requiring continuous treatment and medication with regular monitoring and review.

Once on the general medical ward, Colin met the person who would help keep him alive. The Pharmacist.

As the medicines expert on the team, their specialist knowledge influences everyone who has a hand in Colin's treatment.

Liaising with the medical staff, on medication and avoiding interactions with other medicines.

Advising the nursing staff, on administering Colin's course of treatment. And making sure each dose of medication is adjusted according to Colin's response to the treatment.

Expertise, that Colin's GP and community pharmacist also relied on to continue his treatment, when he left hospital.

As a Pharmacist in the NHS you need to be able to work as part of the team, thrive under pressure and think laterally.

Whether counselling someone like Colin or advising a consultant, your range of skills and specialist qualities will be on call daily. You'll also see how the NHS is changing. Improving working lives. Increasing opportunities for training and scope for career development. And valuing you as an essential member of the healthcare team. If you think you could be a Pharmacist in the NHS, call us now, we're depending on it. 0845 60 60 655

(quote ref: CHM)

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Pharmacists. Join the team and make a difference.

www.nhs.uk/careers

Coming Events

OCTOBER 8

Nottingham Branch, RPSGB
Brain Tumours in Children: Biology and Treatment, by Dr David Walker, at the School of Pharmacy, University of Nottingham, 7.30 for 8pm.

NICPPET
Promoting Change, by Dr Terry Maguire and Ed Sipler, at the White Gables Hotel, Hillsborough, 10am - 5pm.

OCTOBER 9

Oxfordshire Branch, RPSGB
Multidisciplinary Working in the Management of Mental Illness Reflecting the NSF on Mental Illness, by Jenny Ireland, community psychiatric nurse at the George Pickering Postgraduate Centre, John Radcliffe Hospital, 7.30 for 8pm.

NICPPET
Keynote Lectures: Asthma, by Dr Liam Heaney, at the PSNI, 73 University Street, Belfast, 8pm.

OCTOBER 11

Glasgow Branch, RPSGB
2001, A Young Pharmacist's Odyssey, by Noel Wicks, chairman of BPSA at the McCance Building, Richmond Street, University of Strathclyde, 7.30 for 8pm.

NICPPET
From Conception to Birth – The Role of the Pharmacist, at the Silver Birches Hotel, Omagh, 7.30 for 8pm.

OCTOBER 12

NICPPET
Depression and Anxiety, by Peter Pratt, at the Fitzwilliam International Hotel, Antrim, 10am - 5pm.

WEEKLY

Norton follows parent

Norton Healthcare Ltd is now to be known as Ivax Pharmaceuticals UK, incorporating the name of its US parent company.

The re-branding follows extensive market research in the UK, which found that while the Norton brand was perceived as committed, economical and reliable, the new name was considered to be more modern and energetic.

"The adoption of our parent company Ivax's name reflects our key role at the centre of its global operations," said David Blanksby, managing director of Ivax Pharmaceuticals UK .

The company, which has been part of the Ivax group since 1989, said that all contacts and services currently provided would remain unchanged.

For more information:
www.ivax.com

SURVEY

Study shows little impact on independents post-RPM

The abolition of Resale Price Maintenance (RPM) has had little impact on OTC sales in independent pharmacies, according to a study carried out by independent wholesaler Mawdsley-Brooks.

Seventy one per cent of the pharmacists surveyed said that the loss of RPM had made no difference to their turnover, although the remaining 29 per cent admitted to a downturn in sales. The reduction in income, however, was reported to be marginal in most cases.

The survey took place in early September and included 100 of Mawdsley's customers.

The findings appeared to confirm the results of two earlier studies by IMS Health (see *C&D June 16 and July 28*).

Customer loyalty and pharmacy packs were said to have helped to keep sales volumes in pharmacies stable.

Using its own findings as a basis, IMS has suggested that the real post-RPM battle is between the main supermarket chains rather than pharmacies and grocers.

Meanwhile, market analysts Information Resources found that the total demand for OTC products had not increased in volume or value terms as a result of the abolition of RPM *(see also C&D September 29, p32)*.

According to Information Resources, the switch to the grocery sector has been largely restricted to GSL and grocery lines.

However, Mawdsley's marketing manager, Philip Bradley, insisted this was no time to be complacent.

"We are strongly advising our customers to review their OTC medicines in terms of range and presentation," Mr Bradley said.

He pointed out that almost 50 per cent of OTC turnover was generated by medicines, which were space-efficient and profitable compared with other OTC ranges.

Mawdsleys will conduct a follow-up survey in December.

EUROPE

UK firms need to be euro-ready

Whether or not the UK adopts the euro, all UK businesses need to understand the new currency, says the Forum of Private Business (FPB).

The FPB has issued guidance for UK firms on handling the euro, including how to detect forged notes.

The euro will be introduced from January 1, 2002 in 12 European countries. Those countries' previous currencies will no longer be legal tender.

The euro includes some high denomination notes up to €500 (£310) and it is important that staff are familiar with the money.

The FPB also pointed out that businesses had to ensure that invoices sent out to European companies with a due date after the introduction of the euro must must be paid in euros.

For more information:
www.fpb.co.uk.

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* Compared to 4 months for Regaine Regular Strength

PHARMACIA

Comment from the Editor

Wednesday's announcement that the OFT is to investigate the market for retail pharmacy services, and particularly the control of entry regulations, was a bolt out of the blue *(see p5)*. Given the bloody battle the pharmacy sector has recently concluded with the competition watchdog on RPM, further scrutiny is unwelcome.

It will prove divisive as pharmacy businesses look at the commercial consequences (as distinct from the customer/patient benefits) and take a position accordingly. Superdrug lobbied for an end to control of entry during the RPM investigation. Will the grocery multiples seek to exploit this opportunity to put a pharmacy in every store? Struggling e-pharmacy outfits like Pharmacy2U may see it as a chance to develop an online NHS dispensing business, particularly with ETP getting closer *(see p9)*. Independents will remember the leapfrogger...

It will hold up development of primary care pharmacy services within the NHS. For health departments nationally which are trying to bring community pharmacy into a more productive relationship with the NHS, the OFT has thrown a spanner into the works. Since the study will take a minimum of six months, both community pharmacy and the NHS have to mark time when both sides jointly want to make progress.

It could raise real policy issues. In the NHS Pharmacy Plan for England, there is a tacit acceptance that control of entry will underpin a broad availability of services. But the OFT, backed by the Competition Act, could decide whether control of entry is in the public interest, not NHS policy makers. Anti-competitive agreements – if control of entry is viewed as such – are acceptable under limited circumstances where, for example, they contribute or give consumers a reasonable share of benefits. The last thing community pharmacy and the NHS need now is to prove this to the OFT.

The OFT inquiry will hold up development of primary care pharmacy services within the NHS

Yourviews

Chris Tovey, head of retail operations at GlaxoSmithKline, outlines what he sees as the beginning of a new relationship with community pharmacists

A better way of serving pharmacy?

At GSK we are excited about the opportunity our new company has to develop a productive relationship with pharmacists. We are aware that the Glaxo Wellcome agency scheme has been the subject of controversy since it was introduced in 1991.

We will soon be introducing the new GSK trading programme for community pharmacy, at which point the old Glaxo Wellcome scheme will cease to exist.

The new programme is the result of a major rethink of our whole approach and attitude to the pharmacy profession. This rethink was prompted by the merger of SmithKline Beecham and Glaxo Wellcome.

It has been significantly influenced by the extensive consultation process we undertook, during which we reached more than 7,200 national, regional and independent pharmacies, and key professional bodies.

We recognise that for many community pharmacists the old Glaxo Wellcome scheme had certain negative connotations. It was perceived as not valuing pharmacists, not providing adequate access to discount, and inundating pharmacists with complex paperwork.

It is critical that our new trading terms address these concerns. We believe our new approach, based on the feedback we received, will come to represent a new GSK commitment to pharmacy.

We are starting by increasing our investment in pharmacy, giving all community pharmacists greater access to discount deals on products, as well as creating a pharmacy-focused team within GSK to better serve pharmacies' needs.

Chris Tovey: excited about the company's new programme

The new GSK programme remains different from many other approaches. At the core of the new approach is a direct relationship between GSK and pharmacists, which we believe provides the flexibility to best support the pharmacy profession in a changing environment.

Pharmacists are set to play an even greater role in the provision of primary care, as outlined in *Pharmacy in the Future – Implementing the NHS Plan*. In order to perform this role, they will need new sources of support from Government, the NHS and the pharmaceutical industry.

GSK is committed to providing that support and helping pharmacists successfully navigate the changes that lie ahead.

Ultimately, we share a fundamental mission with pharmacists: to optimise patient care through medicines.

gsk

Northern Ireland NOTEBOOK

No hiding from drug problem

The deaths of three young men from drug overdoses hit the headlines recently in Northern Ireland. For the first time, we have had to accept that we have a drugs problem. A drug culture has been growing in strength and prominence since the late 1980s, but has exploded in recent years.

The reality is that a large number of our young people regularly take illicit drugs. Fighting it will require a concerted effort across a range of social and political agencies. Control is the best we can hope for, as the problem is impossible to eradicate.

Pharmacy was in the limelight following the West Belfast deaths, as the police saw prescription drugs as the likely cause.

Some attention needs to be given to prescribing practices. There was a swift response from doctors following the deaths in Belfast. Prescribing of benzodiazapines has been scaled down and weekly amounts are now the order of the day. Ironically it is unlikely that this category of drug was involved in the deaths: those who died had access to MST.

Grandmother's temazepam, for example, can be siphoned off when grandson comes to visit

A less obvious, yet easier, source of drugs is those prescribed them. Grandmother's temazepam, for example, can be siphoned off when grandson comes to visit. I'm not sure much can be done.

There is an urgent need to do something about the problem. Pharmacists have already been subjected to too much violence and stress. How long will it be before there is a more serious incident?

Written by a practising Northern Ireland community pharmacist

TOPICAL REFLECTIONS

So how do asylum seekers fill in an FP10?

The NHS fraud squad is still tightening the screw... and I do have problems with refugees and asylum seekers. These patients present with a prescription but have no papers, no money and no English.

I cannot determine the actual reason for exemption as indicated on the reverse of the FP10 and since there is no box which categorises them I have to assume they receive income support and indicate no evidence produced.

The checking of these claims is an expensive, fruitless exercise but I have no other choice. These families should either be provided with papers that indicate their entitlement to free prescriptions and an extra category added to the FP10, or all pharmacists should be instructed how they are to deal with this invidious situation.

Dream on, Dr Baines!

I read with interest Dr Darrin Baines' suggestions for the future of community pharmacy practice *(C&D September 29, p16)*. I then read them again because I could not believe that he was seriously suggesting a return to the private provision of pharmaceutical services as the solution to the present impasse that is community pharmacy.

The present public culture is one of expectation that health services are provided for free by all practitioners and that community pharmacists are NHS employees.

That this perception is incorrect doesn't concern the public, because it is the expectation that dictates their actions. The result is that I have a client base that is only prepared to pay under the most dire of circumstances and then only after all other sources of free provision have been exhausted.

The only way to change that perception is to change to a privately funded health service, but I live in the real world where political survival requires that the NHS is here to stay.

Private practice as envisaged by Dr Baines only exists as a Utopian dream except in the most exceptional of peculiar demographic circumstances. And in my small suburban pharmacy, viable private practice remains just that – a dream!

DoH still fiddling while I burn

To me the most important parts of the British Pharmaceutical Conference are always the political messages, but equally they are also the most frustrating.

This year a key speaker was the Health Minister, Hazel Blears, and the result was predictable. Once again, I heard mixed messages when I wanted unequivocal support.

The Pharmacy Plan was launched last year in a blaze of publicity, but at grass roots level little seems to have been achieved. It is still business as usual, with regular warnings of doom and gloom over clawbacks, tighter generic pricing and lower dispensing fees.

We are now into October and still the 2001-2002 pay offer awaits agreement, with nothing but excuses from the Department of Health. I do not expect anything dramatic from the current pay negotiations in England and Wales, but instead of providing her DoH officials with excuses for doing nothing, Hazel Blears should be actively addressing the real problem.

The way forward has already been identified. It embraces community pharmacists providing medication management services, helping patients to take responsibility for dealing with their own illnesses, managing repeat prescribing as dependent prescribers, and eventually becoming independent prescribers.

It involves the recognition that the greatest gain to health will come when the community pharmacist is the professional responsible for ensuring that medicines are used effectively and is properly remunerated.

But this will never happen while the present perverse incentive contract of beating the prescription numbers game remains. Its replacement must be the priority, but has been put on the back burner while the ethereal benefits of LPS are further developed.

And at whose expense? I cannot identify LPS with my practice needs, but they are being pursued with a zeal that, as yet, has not explained how they are to be funded.

Pat D'Arcy: pharmacy loses one of its most outstanding figures

Professor Patrick F D'Arcy OBE, BPharm, PhD, DSc, FRPharm S, CChem, FRSC, FPSNI, died suddenly in Glasgow on September 26 while attending the British Pharmaceutical Conference. He was 73.

Patrick D'Arcy was a graduate of the School of Pharmacy, University of London (1952).

His career spanned academic pharmacy and the pharmaceutical industry. In 1958, after lecturing in pharmacology at the School of Pharmacy, he joined Allen & Hanburys as head of its pharmacology department.

In 1962, he left to go to the Sudan to establish a faculty of pharmacy in the University of Khartoum, and stayed until 1967 as professor of pharmacology and Dean of the faculty.

In 1967 he joined Riker Laboratories, Loughborough, and subsequently became the company's technical director.

He joined The Queen's University of Belfast in 1971 on the creation of a chair in pharmacy, a post which he held until his retirement in 1989. He was an emeritus Professor of Pharmacy in the University from that time. He was Dean of the faculty of science at Queen's from 1983 until 1986.

During his time in Northern Ireland, Professor D'Arcy served on numerous boards and committees and became vice-chairman and chairman of the Northern Ireland Health and Social Services Training Council (1979–1986).

Professor D'Arcy was a Freeman of the City of London, a Fellow of the Pharmaceutical Societies of both Northern Ireland and Great Britain, and a Fellow of the Royal Society of Medicine.

He chaired the British Pharmaceutical Science Conference, and was a former vice-president of the Federation International Pharmaceutique (FIP) and a former member of the adjudicating committee of the Royal Pharmaceutical Society of Great Britain. He was a member of the Medicine Commission in London from 1978–1993.

Professor D'Arcy was a consultant for WHO and The British Council on Third World Affairs and pharmaceutical education. In 1978 he was awarded an honorary membership of the American Academy of Pharmaceutical Sciences.

In 1981 he was appointed OBE, and in 1984 was awarded the Harrison Memorial Medal of the RPSGB.

Professor D'Arcy's research centred on the toxicity of drugs, in particular drug interactions. He published over 20 books, including *Iatrogenic Diseases* (Oxford University Press) and *A Manual of Adverse Drug Interactions*. He also contributed over 350 publications to scientific journals. He was executive editor of *The Textbook of Pharmaceutical Medicine*, and editor-in-chief of the *International Journal of Pharmaceutics* from 1977 to 1997.

The funeral took place earlier this week.

Pat D'Arcy, with his late wife Elizabeth, outside Buckingham Palace in 1981, after receiving his OBE from Her Majesty Queen Elizabeth II

'A perfect gentleman'

Professor James McElnay, head of the School of Pharmacy, The Queen's University of Belfast and president of the Pharmaceutical Society of Northern Ireland, pays tribute to his colleague and mentor:

"Pat D'Arcy, was one of the best-known figures in pharmacy within the British Isles. He also had an exemplary international reputation for his work in the field of iatrogenic disease and drug interactions.

I had the pleasure of studying under his supervision for my PhD and then working for him within the School of Pharmacy, which he built within Queen's after pharmacy education moved to the University from the then Belfast Technical College in 1971.

Pat was a perfect gentleman of the "old school" and was well respected by all who worked with him. He was untiring in his efforts to enhance the reputation of pharmacy in Northern Ireland.

He managed, at a time of economic stringencies within higher education funding, to convince the powers-that-be to provide funding for a fine new pharmacy teaching and research building which opened in 1980.

He made an outstanding contribution to university governance, pharmacy internationally (in particular his work for third world pharmacy within FIP), and pharmacy education and research. He also served the pharmacy community in Northern Ireland both on the Council of Pharmaceutical Society and as a member of the Northern Pharmacies Board.

Although he retired from Queen's some 12 years ago he continued to share his knowledge and expertise with undergraduate and postgraduate students and to add to his volume of publications.

The tragedy of Pat's death, at the age of 73, is softened only by the fact that he died having spent his last evening among friends and colleagues as guest of honour at a pharmaceutical sciences dinner at the British Pharmaceutical Conference in Glasgow.

Pat was my mentor, close friend and confidant. His passing has left a gap that will be impossible to fill."

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CONSUMER PHARMACEUTICALS

How can you measure whether customers like the service your pharmacy offers? Anita Broadley, MRPharmS, Moss's central operations executive and Leigh Machell, MRPharmS, its professional development manager, offer the chain's model as a pointer

Customer satisfaction

When you are running more than 700 pharmacies, how can you ensure every outlet offers top quality customer service? Moss Pharmacy's solution reflects the resources at its disposal, but it can be adapted by independent pharmacists to monitor and improve their own standards.

It helps to know what your aim is – most companies have a mission statement that explains this. Moss's is: "To make a difference to our customers by delivering better healthcare."

But a mission statement in itself does not guarantee good pharmacy standards. You need to find out what your customers think, and where they would like to see improvements.

Equally important, your staff need to know what standards they have to meet. And, in Moss's case, the challenge is to ensure customers enjoy the same standards, no matter which branch they go into.

Moss ran a small-scale survey in 50 branches to identify the most important areas for delivering customer satisfaction.

These key drivers generally related to three elements – shop, service and staff (the three S's) – and from there it developed a list of 16 standards, representing the Moss vision of excellence.

Having put its standards in place in July 2000, it undertook a customer survey in all its pharmacies and received more than 25,000 responses. Ninety-six per cent of its customers said they were always satisfied with visits to the chain's stores, and 98 per cent said staff were always approachable, available to serve them promptly, and they were always served in a helpful and professional manner.

However, any survey of existing customers is bound to show a positive bias – they wouldn't be at the pharmacy if they didn't like it. More relevant, therefore, was the priority that customers gave to different aspects of our service. Moss's customers' top 10 priorities were:

- helpful and professional service
- stock availability
- value for money
- product knowledge
- staff availability and approachability
- staff friendliness
- prescription waiting time
- information on prescription waiting time
- shop presentation
- information on stock availability.

Equally important was how well Moss's staff understood its customers and what was important to them. By understanding these needs the staff would be able to provide a service that exceeded customers' expectations.

Using a so-called "mirror" survey Moss investigated whether its staff had the same perceptions as its customers. The questionnaire also reflected how far those working within the pharmacies thought it was meeting customers' needs.

Overall, customers and staff seemed to be on the same wavelength, but there were variations at branch level. Interestingly, staff rated their pharmacies' presentation and their own availability consistently lower than customers.

For example, 98 per cent of customers, as opposed to 84 per cent of staff, felt the pharmacy was well presented, clean and tidy. Three per cent of staff were concerned that they were not always available to serve customers promptly, whereas only one customer in every 100 felt this was an issue.

This seems to suggest that staff were not unduly complacent about their performance, and had a healthy, but not excessive, appreciation of room for improvement.

By plotting the results from this mirror survey in a graphic form we have been able to highlight any areas of dissimilarity in our staff's thinking to the way our customers thought *(see Fig 1)*. This exercise has been extremely helpful, in that it has drawn to our attention areas in which some branches did not seem to understand their customers as well as they might.

Having a clearly defined, geographically-based company structure, we have also been able to pool results and analyse them at area and regional level. This has given us a valuable means of identifying trends around the country, allowing us to evaluate the effect of any changes we make to the way our branches operate.

Every pharmacy is unique and this makes it difficult to assess "excellence" between branches. However, by developing these 16 standards we now have a means of judging fairly each branch, and determining how well each is performing.

This not only allows us to compare branch with branch, area with area, but also (and perhaps more importantly) gives us a good

Continued on page 20

NEW

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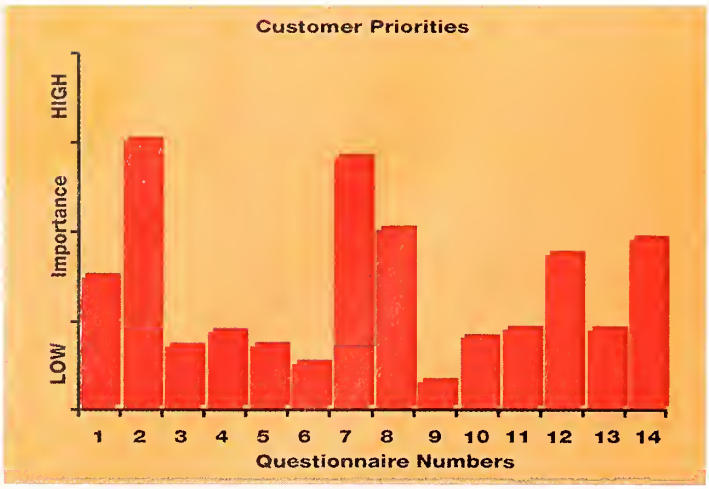


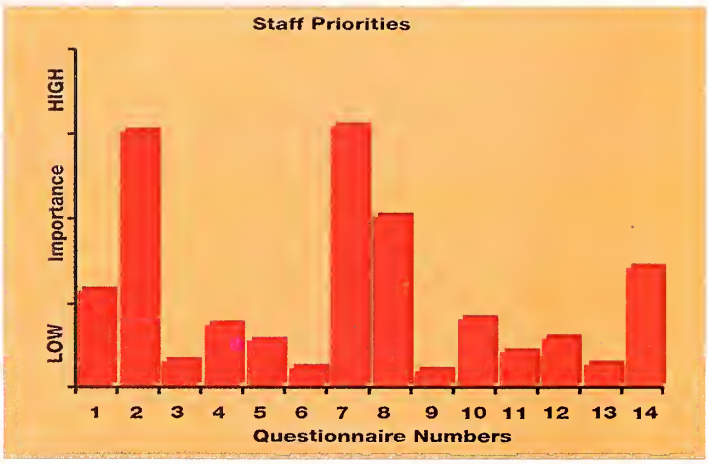


Fig1: A mirror survey can be used to investigate whether staff have the same perceptions about the store as their customers

The Moss standard

Top priorities include:
- presentation, hygiene
- approachable/presentable staff
- dispensing prescriptions
- added value service
- stock availability
- short waiting times
- handling customer's telephone calls efficiently
- handling complaints
- customers encouraged to come again
- staff presentation
- customers acknowledged when entering the pharmacy
- customers greeted politely
- customers served in a professional/helpful manner
- product knowledge/staff training.

◀ *Continued from page 18*

method of tracking how a pharmacy is improving over time.

To check on progress, area managers will be assessing individual branches against the standards twice a year, and the staff and customers will be asked to do the same annually.

No matter how good your service, you need to know how you can improve it. Standing still cannot be an option. Customers change and their expectations change, and we need to be able to respond to, or predict, those changes.

One of the key factors in delivering quality of performance is to have the right culture. It is important therefore that our head office has the same ethos as branch staff.

Having set out a clear vision of what we expect from our branches, it is only logical that head office should work towards a similar goal. We have therefore recently finished a similar process to determine how our head office should operate to meet the needs of our customers – both internal and external.

The outcome is a second set of standards, in this case designed to be appropriate to the head office environment.

These standards focus on courtesy and prompt handling of queries from our customers, whether inside or outside the company. They also address communication with branches (eg through regular visits) and a commitment to best working practices within departments.

You could argue that we have merely been stating the obvious with our branch standards exercise. After all, having a clean and tidy shop is surely bound to be a factor in maintaining customer satisfaction.

However, there is danger in making such assumptions. Perhaps, as our mirror survey suggested, your understanding of the customer's needs and expectations does not tally with their true thoughts. If this is the case, much time and effort, not to mention money, may be invested in developing and improving something that, for the customer at least, is a low priority.

Another tremendous advantage of the exercise is the simple fact that it forces you to take stock of where you are and, if done properly, how you are performing over time.

Granted, there may be factors over which you have little control, but there will be other areas that you can influence.

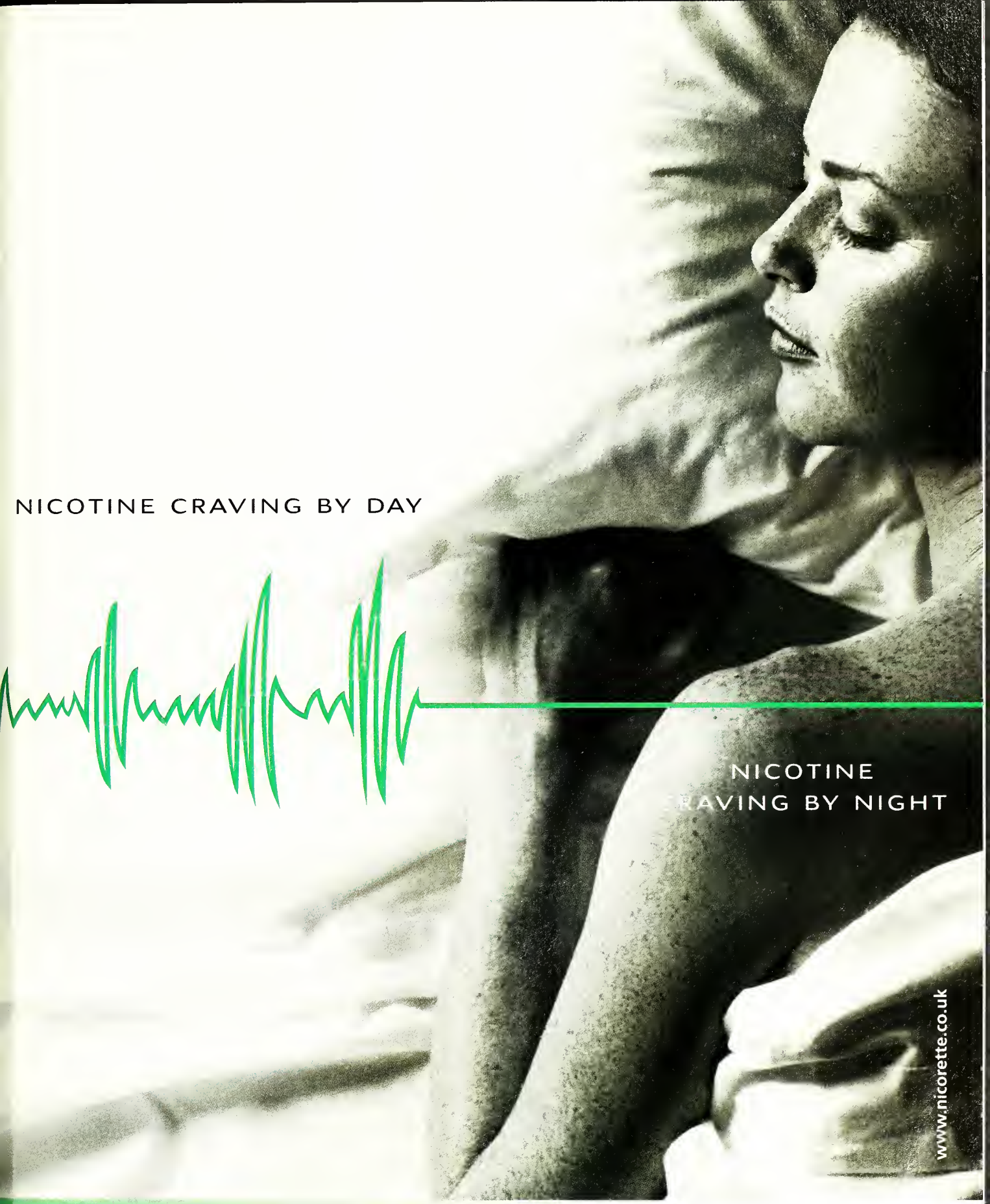
With more than 700 branches, we needed to develop a mechanism whereby our area managers could consistently grade our shops. We also needed to know that all branches, whether in Cornwall, Norfolk or the Highlands of Scotland, were all being judged by the same standards. Crucially, every member of staff also needed to know exactly what those criteria were.

Nevertheless, whether you operate 700 branches, 70 or just one, excellence is something to which we should all aspire. Although the research that we have carried out is specific to Moss, there are lessons to be drawn for all retail pharmacies.

Customer satisfaction cannot be taken for granted. And even if you do find a high level of satisfaction among your customers (as we did), what about the others? What about the people who are not your customers?

Perhaps, by identifying the areas that existing customers are least happy with, you can do something to improve your attractiveness to people who do not use your pharmacy at present?

No matter how big your organisation, there is a danger that, unless every member of staff is clear about the destination, you might all head off in different directions.



Smokers don't smoke while they sleep, so why provide them with nicotine replacement therapy all night? Nicorette 16 hour Patch closely mimics a regular smoker's nicotine intake during normal waking hours. Because it keeps cravings under control all day, but leaves smokers nicotine-free at night, there's less chance of sleep disturbance! So next time regular smokers need continuous craving relief, help them have a restful night too, with Nicorette 16 hour Patch.

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nicotine
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MAKE STOMACHS HAPPY

Heartburn and indigestion relief that...

GOES TO WORK IN 2 MINUTES...

... AND LASTS FOR UP TO 12 HOURS

Only Pepcidtwo works in two minutes and lasts for twelve hou

Johnson & Johnson

With the flu season imminent, *Dr Nicol Black*, a consultant in communicable disease control, suggests ways pharmacists can help in immunisation

Selling vaccines

THE COLLEGE OF PHARMACY PRACTICE

This course (code 1214) in association with multiple-choice questions being published in C&D November 10, provides one hour's continuing education

Objectives

- To be aware of the diseases for which vaccines are available
- To understand the health implications of low vaccine uptake
- To know which vaccines to recommend to UK patients
- To be able to advise on vaccinations for travellers
- To be aware of public concerns over certain vaccines

As purveyors of safe medicines, pharmacists have a long established role in the (cold-chain) storage and supply of vaccine.

In their other traditional role of advising on medicines, they have always interfaced directly with primary care staff, often with advice and guidance flowing there as well as to the patient.

As public interest in vaccines steadily grows, fuelled not least by well-publicised stories about vaccine safety, it is time to reconsider whether pharmacists' contribution as "vaccine ambassadors" is being fully exploited.

Worldwide, vaccines are the most cost-effective means of preventing communicable diseases. Paradoxically, as societies become more highly developed and illness rates fall, the feeling that "nothing will happen to me" gains ground and parental pressure for immunisation wanes.

Folk memory of immunisable infections steadily recedes with each year's intake to retirement homes. As the onus of ensuring that children are protected begins to fall on healthcare workers, their commitment and enthusiasm become increasingly important.

So, what are the challenges? Keeping abreast of new vaccines, new diseases, developments in childhood schedules, adult and travel vaccines and, of course, safety.

New vaccines

With the explosion of molecular genetics, new techniques to "build a better mouse trap" are proliferating as never before. Sequencing the human and microbial genomes will make possible advances that we can now only imagine. Vaccines that are likely to come into service in the near future are described below.

New diseases

Diseases seem to be identified or re-emerge constantly. At least 30 previously unknown disease agents have been identified since 1973, including HIV, Ebola, hepatitis C, rotavirus, Legionnaire's disease, *E coli* 0157, Lymes disease, *Helicobacter pylori*, vCJD and Nipah virus.

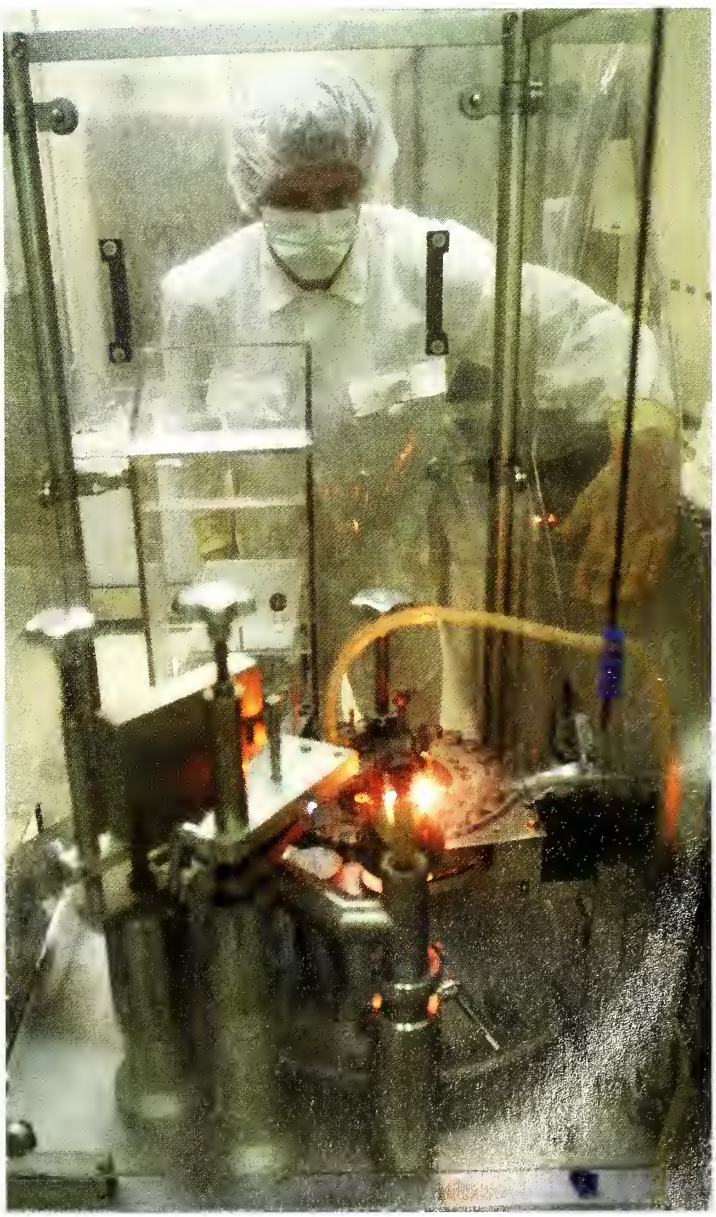
Many diseases which have re-emerged or spread geographically are often in more virulent and drug-resistant forms, including tuberculosis, malaria, cholera and West Nile virus. Many drug-resistant organisms have emerged, including penicillin-resistant *Streptococcus pneumoniae*, methicillin-resistant *Staphylococcus aureus* and resistant *Mycobacterium tuberculosis*.

Perhaps the most visible change recently is the expansion of adult immunisation.

Influenza

Increasing emphasis has been given in the last few years to preventing influenza in those especially susceptible to adverse complications, which include people with chronic diseases, especially cardio-respiratory disease and those in long-stay residential accommodation for the elderly. In 2000, the Department of Health, for the first time, set a

Continued on page 24 ▶



Vaccine production: a pharmaceutical technician supervises an automatic stage in the production of vaccines

Continued from page 23

target of 60 per cent vaccination rates for those aged 65 or over.

The results were uneven, ranging from 34 to 77 per cent by health authority and some practices were struggling. Why so? There was national publicity, including a television campaign featuring Sir Henry Cooper, many local media campaigns, invitation letters sent out, reminders with repeat prescriptions and a host of similar local initiatives.

Popular explanations are that people think they will develop influenza after an immunisation, or that the elderly are often too confused to give valid consent.

As the vaccine contains inactivated or incomplete virus particles, infection cannot occur. Vaccine administration is usually during October so is likely, in our climate, to coincide with other coryzal infections and such mistaken cause-and-effect associations are more easily made than refuted. However, given the confusion between true influenza and "flu", the catch-all term for a rag-bag of different respiratory viral infections, this is unsurprising.

There are clinical rule-of-thumb differentiations from "the flu", such as the £50 note test (if there is a £50 note lying beside your bed and you feel too ill to pick it up, the chances are you have influenza rather than "flu").

The case definition for influenza is an abrupt onset of cough, fever and at least one somatic symptom of muscle ache, headache or malaise.

Differentiating between influenza and other viral illnesses is not unimportant; it prevents trivialising a potentially serious illness in the elderly, which has significant morbidity and mortality and accounts for much of the seasonal rise in acute hospital admissions each winter.

The development of enhanced virological surveillance over the winter is welcome, not only for monitoring vaccine efficacy, but also to discourage the inappropriate prescribing of influenza-specific drugs like zanamivir (the PHLS website is particularly helpful here).

One health authority in North East England, which has had active involvement with nursing and residential homes for several years, achieved 80 per cent uptake compared with 65 per cent in general practice (author's data).

This illustrates that sustained encouragement pays off. If patients are not coming forward for immunisation, they clearly do not value the protection offered (uptake rates of optional immunisation in some acute hospitals hovers at 10 per cent).

In any immunisation campaign, strong professional commitment is the key to success or failure. How about vaccine advocacy with every bottle of cough syrup sold this year?

Pneumococcal disease

Much morbidity and mortality in influenza is caused by secondary bacterial pneumonia and *Strep. pneumoniae* is the most commonly identified organism. A vaccine has been available for several years, which prevents invasive disease with an efficacy against pneumonia of 60–70 per cent. But it is widely under-used. Unlike childhood conjugate pneumococcal vaccine *(see below)*, it is a 23-valent polysaccharide vaccine offering adults immunity for five to 10 years.

Indications for its use are virtually the same as for influenza, but also include splenectomised patients, so it seems illogical to immunise against one disease without immunising against the other. Unlike influenza vaccine, the pneumococcal vaccine does not require reformulation each year. It can conveniently be given at the same time as the influenza vaccine, but not necessarily.

Annual uptake in the UK is about 6–7 per cent per annum (PPA data), though with vigorous endorsement this can be increased to 27 per cent (author's data). A recent published study showed that most GPs were aware of the vaccine but had yet to commit themselves to using it.

Pharmacists could rack up the advice to patients and primary care alike for this vaccine to be as widely used as the influenza vaccine.

The next major advance, which will be with us soon, is the conjugate pneumococcal vaccine (CPV). Pneumococcal disease is so insidious that its prevalence is widely under-recognised. The majority of cases occur in babies and toddlers less than two years old. CPV has been shown to be effective in preventing meningitis, pneumonia and otitis media and is awaiting adoption by the Joint Committee on Vaccination and Immunisation.

Although there are many strains of *Strep. pneumoniae* in circulation, the seven valent vaccine protects against 80 per cent of those strains causing illness in the six-month to one-year group and also against the "vast majority" of penicillin-resistant isolates.

The "conjugate" uses the same trick as in HIB and meningococcal C vaccines in that attaching a bit of tetanus toxoid induces long-term immunological memory, with sustained high level protection.

Meningococcus

In the UK, the outstanding recent success is the conjugate meningococcal C vaccine, which has virtually eliminated this strain in children who have been immunised. This is especially noticeable in school-aged teenagers, so much so that the need for emergency immunisation programmes in schools now seems gone for good.

The prospect of a B group vaccine remains tantalisingly on the horizon, with optimistic estimates of availability in 2003.

Hepatitis B

Between 80–90 per cent of people immunised with hepatitis B vaccine will mount a protective response, which can be readily boosted. As those aged over 40 are less likely to respond, why not immunise all children, as is routine in the USA?

Many teenagers flirt with risk activities for HBV including intravenous drug usage or unprotected sex with multiple partners. As the prevalence of HBV rises, so too does the number of chronic carriers.

Two-thirds of infections are asymptomatic and may escape diagnosis. Seroprevalence varies at least tenfold geographically in the UK, with rates of one per 100 attending antenatal clinics in some inner city areas.

Although a cause for concern, these rates are low by international standards. As the goal of a successful hepatitis B vaccination campaign should be to achieve a prevalence lower than 2 per cent, routine immunisation in the UK looks less likely than locally targeted initiatives, such as inmates of custodial institutions, parenteral drug misusers or individuals who change sexual partners frequently.

Polio

So far, smallpox is the only infectious disease to be eradicated from the world by vaccination. The prospects are growing that polio may follow soon. Polio can be eradicated because it only affects humans, effective vaccines exist, immunity is lifelong, there are no long-term carriers, and the virus can only survive in the environment for a short time.

The World Health Assembly resolved to eradicate polio worldwide in 1988 and, by massive vaccination campaigns, has reduced the intensity of world polio transmission dramatically.

Only India/Pakistan and a few parts of Africa still have wild virus circulating. The mainstay of these programmes is oral polio vaccine (OPV); this produces serum antibodies which protect against paralysis, as well as a mucosal immune response, which prevents multiplication of wild virus.

The downside of OPV is that in extremely rare cases (approximately one in every three million doses of vaccine) the live attenuated virus can cause paralysis, either in the vaccinated child or in a close contact, especially if they are immunocompromised. As such, some European countries are considering combined schedules using both OPV and inactivated polio vaccine by injection.

In the UK, only 14 cases of acute poliomyelitis have been reported in the last 10 years, with most of these being in unimmunised children from abroad. There are no plans to introduce combined schedules in the UK.

Measles

Measles is also potentially eradicable, if effective administrative strategies are rigorously followed. Measles is so highly infectious that without vaccination every child will acquire it. With incomplete immunisation, the inter-epidemic period is prolonged rather than prevented as the pool of susceptible individuals grows until an outbreak occurs.

In the UK, clinical notification of measles has declined by 75 per cent in the past decade but the serological confirmation has risen from 1–3 per cent in the past three years (PHLS data).

The controversy surrounding autism and MMR, fuelled by press articles, continues to frighten off parents, resulting in a 4 per cent drop in children being immunised in the last three years. Last year there were two outbreaks in Ireland and Holland with 3,400 cases and five deaths.

Continued on page 26

PROFORE* kits

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For the Nurse

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- Fulfilling a prescription is quick with all components already in one neat kit box
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To receive an ordering card detailing PROFORE kits and all the order codes, fill in your details below. Make life easier for you and the nurse:

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Return the slip to Ann Hughes, Smith & Nephew Healthcare Ltd, Healthcare House, Goulton Street, Hull HU3 4DJ. Alternatively email: advice@smith-nephew.com detailing your request and leave your name and address.

Profore*

Proven clinical & cost effectiveness

Continued from page 24

In contrast, a prospective study of immunising 1.8 million Finns with 3 million doses of MMR, with a 14-year follow up period, showed no more than three adverse effects of any description for every 100,000 doses of the vaccine and no cases of autism.

The safety of MMR vaccine is outstanding, with over 50 million doses used in 90 countries since the 1970s. The moral is to take peoples' concerns about adverse effects seriously, but not to speculate in public.

Travel

Each year 60 per cent of the UK population travels abroad and long-haul flights to exotic destinations are becoming increasingly popular. Up to 70 per cent of these travellers will develop some degree of infective illness and half will lose on average three of their 14 days of travel. But deaths are rare, accounting for only about 3-4 per cent of travel-related deaths.

Travel vaccines most often given are typhoid, yellow fever, *hepatitis A* and meningococcal A/C vaccine for travellers to sub-Saharan Africa and the Himalayas. Less commonly, rabies, meningococcal W135 for pilgrims to the Hajj and Japanese encephalitis for stays of a month or longer in South-east Asia, especially during the monsoon season, may be required. Advising on travel vaccines is best left to specialised sources.

Malaria is the major life threatening infection in travellers. The worldwide incidence of malaria is rising, as is resistance to chloroquine. The mortality rate of *falciparum* malaria is also rising, from 15 to 30 per cent.

Although chemoprophylaxis is not 100 per cent effective, most cases are due to either failure to take prophylaxis, inappropriate choice of prophylaxis, or insufficient avoidance of mosquito bites with sprays and bed netting.

Importantly, most travellers develop malaria after the return home and a travel history is all-important if recent travellers become unwell.

As an alternative to prophylaxis, which often has intolerance problems or side effects, a vaccine against malaria, however desirable, continues to be a distant prospect. Two types of vaccine have been in clinical trials, against either the asexual or sporozoite stages. The asexual vaccine produced a modest reduction in incidence of *P falciparum* in South America, but not in Africa, and the sporozoite vaccine showed no evidence of protection.

This picture is similar for vaccines against the other major killers, HIV and tuberculosis. A number of obstacles have barred the development of these vaccines, including antigenic diversity, lack of good animal models, poor understanding of the immune correlates of immunity, difficulty in determining protective responses to a vaccine and cost.

Rabies

Rabies is so rare in the UK that if it were not for quarantine restrictions, most Britons would be blissfully unaware of it. The last case indigenously acquired in the UK was in 1902, though worldwide it is estimated that there are 35-40,000 cases per year, almost all in developing countries. Since 1976, 11 cases, all imported, have been diagnosed in England and Wales.

The vaccine used in the UK is the human diploid cell vaccine (HDCV), recommended for those who occupationally handle imported animals or those people living in enzootic areas or travelling where medical treatment may not be available.

Pre-exposure administration is two to three doses by deep intra-muscular injection, although intra-dermal administration by experienced personnel is reliable in certain circumstances. In the event of a possible rabies exposure abroad, early local advice is essential, as the likelihood of rabies in the locality will be well known. Subsequent treatment will depend on the level of risk, whether or not the individual is fully immunised. This consists of two or five doses of HDCV, perhaps with human rabies-specific immunoglobulin as well.

Outlook

However many vaccines there are, and however effective they may be, they are only useful if they are given reliably and comprehensively. More antigens in the childhood schedules mean ever more injections, until combined vaccines are produced.

Increasing emphasis on adult vaccines means developing outreach services for the non-ambulant needy, with greater use of group protocols and nurse-led co-ordination. This enhanced primary-care team activity looks promising, but will inevitably increase the number and range of vaccine-related queries coming the pharmacists' way.

There are more online sources of information and advice than ever before; *www.phls.org.uk*, *www.doh.gov.uk*, *www.who.int* and *www.cdc.gov* are good starting points. But there is no substitute for the reassurance that comes with voicing worries with a trusted advisor and having calm, empathic rationality strip away the emotional blinkers.

Maintaining health is as important as getting medication when a person is symptomatic. Pharmacists should have a vital role here advising people, particularly the elderly, and being local advocates for immunisation.

Know your own strengths, integrate and interact with your local "experts" and help the world spin a little more safely.

Further reading

1. Immunisation: causes of failure and strategies and tactics for success.
2. British Medical Journal 1989 vol 299 p808-812
3. Infectious diseases yesterday, today and tomorrow; we can change the world.
4. Anne A Gershon 38th Annual meeting of the Infectious Diseases Society of America, New Orleans September 2000 (access on www.medscape.com)
5. Vaccines: looking into the crystal ball
6. Anne A Gershon 37th Annual meeting of the Infectious Diseases Society of America, Philadelphia 1999
7. Advances in influenza treatment and control
8. Kathy Neuzil 38th Annual meeting of the Infectious Diseases Society of America
9. New Orleans September 2000
10. Disease eradication as a public health strategy; a case study of poliomyelitis eradication
11. R B Aylward, H F Hull, S L Cochi, R W Sutter, J-M Olive & B Melgaard
12. Bulletin of the World Health Organisation 2000 vol 78 (3) p285-297

● *Dr Black is a consultant in communicable disease control, North of Tyne Communicable Disease Control Unit, Newcastle General Hospital*

Actionplan

1. In your practice workbook list the differential diagnosis between colds and influenza. Instruct your counter staff of the important points so they can give appropriate advice to your patients.

2. Devise a strategy to increase the uptake of influenza vaccination this year. Think about how you can achieve a greater than 75 per cent uptake by the over 65 year olds. Discuss this with your local doctors.

3. Look in your fridge and make sure you have enough of the vaccines that are supplied through pharmacy.

4. Read as much as you can about the MMR vaccine so you can advise your clients on its safety and effieacy (*see also C&D Pharmacy Update May 5, pXI-XII)*. Perhaps note in your practice workbook a summary of the results of the various trial reports, which indicate its benefits and drawbacks.

The article suggests that advice on travel vaccination is best left to experts. Do you agree? What do you and should you know? If you did not have chanee to complete the action plan on malaria prophylaxis(*C&D Pharmacy Update August 4, pVII-VIII)*, try to update your knowledge now.

Following the successful introduction of Xatral XL 10mg o.d., we are phasing out Xatral SR 5mg b.d. in November. This means that patients on Xatral SR can be switched to Xatral XL 10mg o.d. at the earliest opportunity. Good news for your patients!

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esentation: Xatral XL tablets containing 10 mg alfuzosin hydrochloride in a prolonged ease formulation. Xatral tablets containing 2.5mg alfuzosin hydrochloride.
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osage: Initial dose should be taken before bedtime.
ults Xatral XL – one tablet to be taken daily after a meal. Tablet should be swallowed hole. Xatral – one tablet (2.5mg) three times daily increasing to four tablets per day required.
derly and treated hypertensive patients Xatral XL – no dose adjustment required. tral – one tablet (2.5mg) twice daily (morning and evening).
nal insufficiency Xatral XL – no dose adjustment required in patients with mild to oderate renal impairment. Experience in patients with severe renal impairment is nited and cautious use in these patients is recommended.
tral – one tablet (2.5mg) twice daily (morning and evening) adjusted according to nical response.
patic insufficiency Mild to moderate: single dose of Xatral 2.5mg per day, increasing to 5mg twice daily according to clinical response.

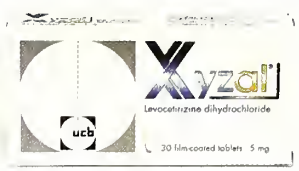
Contraindications: Hypersensitivity to alfuzosin, history of orthostatic hypotension, co-administration with other alpha blockers, severe hepatic insufficiency.
Warnings: Postural hypotension with or without symptoms may occur in some subjects, in particular, patients receiving antihypertensive medications. These effects are transient and do not usually prevent continuation of treatment following dose adjustment.
Precautions: Initiate treatment gradually in patients who have shown hypersensitivity to alpha blockers and in patients taking anti-hypertensive drugs. Continue specific anti-anginal therapy in patients with coronary insufficiency. Discontinue Xatral XL or Xatral if angina reappears or worsens. Withdraw 24 hours before surgery.
Side Effects: Most frequently observed side effects are faintness, vertigo, dizziness or malaise, headache, minor gastrointestinal disorders.
Basic NHS Cost: Xatral XL 10mg blister packs of 30 tablets £23.80; Xatral 2.5mg blister packs of 60 tablets £19.00.
Legal Category: POM.
Product Licence Number: Xatral XL: PL 11723/0370. Xatral: PL 11723/0329.
Product Licence Holder: Sanofi-Synthelabo, PO Box 597, Guildford, Surrey.
Date of Preparation: September 2001.

XAT 01 129

Scriptlines

Cetirizine isomer launched

Xyzal (levocetirizine) 5mg tablets have been launched by UCB this week. Xyzal is a prescription-only antihistamine, for use in allergic rhinitis and chronic idiopathic urticaria. The dose is one 5mg tablet daily for adults and children over six. Xyzal does not impair mental alertness, reaction



times or driving ability. Studies have shown that levocetirizine has double the affinity for H_1 receptors compared to cetirizine. UCB has no plans to discontinue Zirtek (cetirizine) tablets.

Price: £7.45

Pack size: 30 tablets
Pip code : 282-7988
UCB Pharma Ltd
Tel: 01923 211811.

Plavix SPC update

The SPC for Plavix (clopidogrel) has been updated to highlight new side effects. Blood cell count determination should be performed during the first week of treatment, where Plavix is co-administered with aspirin, NSAIDs, heparin, glycoprotein IIb/IIIa inhibitors or thrombolytics, and in patients at risk of bleeding from trauma or surgery. Undesirable effects now include serious cases of bleeding, thrombocytopenia, renal disorders, allergic reactions, taste disorders and confusion.

For more information:

Sanofi Synthelabo Ltd
Tel: 01483 505515.

Epoetin beta dose update

NeoRecormon (epoetin beta) is now licensed for once weekly administration in the treatment of renal anaemia. Studies have demonstrated that once weekly dosing is as efficacious as three times weekly for NeoRecormon.

For more information:

Roche Products Ltd
Tel: 01707 366000.

Frontshop

Food intolerance test kit available in pharmacies

York Nutritional Laboratories is launching its Foodscan food intolerance test into pharmacies nationwide this month.

The test was previously only available by mail order and in Lloydspharmacy stores.

The ELISA analysed pin-prick test helps customers identify "problem foods" which can worsen conditions such as asthma, eczema, IBS, migraine and arthritis. Over 45 per cent of the population suffer from illnesses that have been linked to food intolerance.

Customers can pick up an information booklet and order a kit in-store.

The test kit will arrive the following day, enabling customers to collect their tiny pinprick blood sample (50 microlitres).

This is sent to York Nutritional Laboratories, which will return an analysis within 14 days, together with a food intolerance guidebook.

The range includes two tests – a 42-food screen and an in-depth 113-food test.

The tests include a telephone consultation with a nutrition consultant, a year's membership of the British Allergy Foundation, plus extra advice and support materials.

The range will be supported with a £500,000 marketing campaign including women's press advertising in November/December and a promotional campaign to communicate that "better health begins at home".

Price: 42-food screen £125; 113-food test £245

York Nutritional Laboratories
Tel: 0800 074 6185.

New Vitabiotics capsules could be a smart move

Vitabiotics is launching a multivitamin supplement formulated to help maintain different aspects of cognitive health, including brain function, memory and performance.

Neurozan capsules contain phosphatidylserine, co-enzyme Q10, highly concentrated DHA and a range of vitamins, minerals and carotenoids.

The manufacturer says that people who may benefit from the product include those under large amounts of incredibly challenging work pressure and older men and women at risk of declining mental functioning.

Price: £8.95

Pack size: 30 capsules
Pip code: 274-9984
Vitabiotics Ltd
Tel: 020 8902 4455.

Have ginger, will travel

Herbal Concepts is launching a natural supplement for stomach discomfort when travelling.

TravelGinger contains organic ginger root for its soothing effect on the stomach. The capsules also include a combination of vitamins C, B3, B6 and K to aid normal gastric functioning.

Two capsules should be taken an hour before travelling and again three hours into the journey.

The product is suitable for children, adults and the elderly, but should not be given to infants or babies. It has recognised organic and vegetarian status.

Price: £7.99

Pack size: 30 capsules
Pip code: 283-1014
Herbal Concepts Ltd
Tel: 01296 689045.

Getting a grip on pain

Retail Club Direct is introducing a triple-action, drug-free pain relief device into UK pharmacies.

Pain Master is a hand held device that combines three therapies – direct TENS frequencies, natural magnetic fields and stimulating acupressure.

It is designed to help relieve the pain of arthritis, osteo-arthritis, back pain, sciatica, joint pain, rheumatism and osteoporosis.

A selection of treatment heads is available to treat different parts of the body including hard to reach areas like the back, shoulders and large muscle areas, as well as joints such as fingers and knees.

Point of sale material includes colour leaflets, a showcard and a leaflet dispenser.

Special deals are available for pharmacies.

Price: £69.95

Retail Club Direct
Tel: 0870 2000 1000.

new
350g tub

Big is better

Now there's plenty of room for your sales to grow, because clinically proven E45 Cream is available in a new bigger 350g tub. Which is great news for your customers, because using more of the No.1 emollient cream means even better results. So stock up now. After all, you can't have too much of a good thing.

White Soft Paraffin, Light Liquid Paraffin, Hypoallergenic Anhydrous Lanolin

Eight young pharmacists shortlisted for awards

This summer UniChem launched the first ever Young Pharmacist Business Awards and invited pre-reg students and pharmacists who have qualified within the last five years to tell us how they see independent retail pharmacy in the future.

Now, with just six weeks to go until the Awards ceremony, we can announce the eight finalists who have made the shortlist and who will be invited to UniChem's Great Business Awards, held on 16 November at the Metropole Hotel in Birmingham.

The finalists are:

- Sarah Mapes, Norwich
- Jaymani Patel, Dudley
- Abim Ayoola, Essex
- Noel Wicks, Stirling
- Benjamin Genis, Cornwall
- Lorna Holness, Middlesex
- Mike Barbour, Thaxted
- Pamela Ann Gale, Southampton.

But there can be only one winner, who will be announced at the gala dinner, along with three runners up. The winner will receive a £2,000 business bursary and a jet set tour of five different European pharmacies thanks to Alliance UniChem's European network. The runners up will receive £800 worth of PC equipment each.

Here is a round up of some of our finalist's predictions for how independent retail pharmacy will be in 2020:

- Pharmacy consulting rooms for screening programmes
- Medicines will be directly supplied to patients' homes from the wholesaler
- One pharmacy organisation under which independents can exchange surplus stock, share advertising etc
- Pharmacist prescribing
- Robotic dispensing
- Paper-free pharmacy
- Video links to GPs
- Paper-less pharmacy, as E-communication will have taken over
- NHS intranet
- Pharmacists working in lunar colonies
- Independent pharmacists running apprenticeship business workshops for young pharmacists
- Remuneration for additional services offered by the pharmacist.

The judging panel will be carefully scrutinising each entry, but readers of Chemist & Druggist can have their say too. Check out all the finalists' entries on www.dotpharmacy.com and cast your vote. The poll will close on 15 October.

Young Pharmacist Business Award

a UniChem initiative

UniChem

Frontshop

P&G launches a really soft touch from Oil of Olay

Procter & Gamble is launching four moisturising products in its Oil of Olay skincare range.

Olay Touch Sensory Moisturiser has a delivery system designed to carry high levels of moisture to the skin for up to 24 hours.

The formulation includes "sensory smoothers" to help the product to glide onto the skin, leaving a satin-smooth feel.

To retexturise the skin, the vitamin B3 or niacinamide in the formula helps boost cell renewal in the upper layers of the skin.

The moisturiser is available in two lotions (one with SPF15) and two creams (one with SPF15).

Price: Lotion £5.99; Cream £6.99

Pack size: Lotion 100ml; Cream 50ml
Pip code : Lotion 280-4748; Lotion with SPF15 280-4888; Cream 280-4870; Cream SPF 15 280-4730
Procter & Gamble UK
Tel: 01932 896000.

Aquafresh duo brush up their act on TV

GlaxoSmithKline Consumer Healthcare is supporting its Aquafresh Multi-Action + Whitening toothpaste and Aquafresh Max Active toothbrush with a £1.6 million TV campaign this month.

The TV commercial focuses on a newly-married couple who discover that Aquafresh Multi Action+ Whitening brings together protection plus whitening to suit both their dental care needs – thus avoiding any compromise or argument.

Further TV support for the Aquafresh brand is planned for the end of the year.

For more information:

GlaxoSmithKline Consumer Healthcare
Tel: 020 8560 5151.

Calpol Fast melts focuses on mums

Warner Lambert Consumer Healthcare is supporting its Calpol Fast melts with a £4 million advertising and promotional programme this autumn.

A national TV advertising campaign targeting parents will be on air until November.

The advertising focuses on modern mums and their energetic children.

Each commercial finishes with a reassuring image of a mother soothing her child after administering Calpol Fast melts. The paracetamol-based melt-in-the-mouth tablet is targeted at children aged 6-12.

For more information:

Warner Lambert Consumer Healthcare
Tel: 023 8064 1400.

Scriptlines

Typhoid and hep A mix

Aventis Pasteur has launched ViATIM, a combined purified Vi polysaccharide typhoid and inactivated hepatitis A vaccine.

It is indicated for immunisation against typhoid fever and hepatitis virus infection in patients aged from 16.

ViATIM is administered by slow intramuscular injection in the deltoid region. Fourteen days after vaccination, 86 per cent of patients had seroconverted against typhoid fever and 95 per cent against hepatitis A.

A booster injection of inactivated hepatitis A should be given six to 12 months later and revaccination against typhoid fever should be carried out after three years.The vaccine must be stored between 2-8°C.

Price: £32.49

Pack size: 1ml prefilled syringe
Pip code: 282-5800
Aventis Pasteur MSD
Tel: 01628 785291.

Leo drops brand names

Leo Pharmaceuticals will be dropping the brand names from its heparin range. The Heplok (heparin sodium 10IU/ml), Hep-Flush (heparin sodium 100IU/ml) and Pump-Hep (heparin sodium 1,000IU/ml) names will be replaced by the generic name. They are also dropping the Burinex (bumetanide) brand name from Burinex liquid and injection, with immediate effect. Burinex tablets are not affected.

For more information:

Pip code: see Price List
Leo Pharmaceuticals
Tel: 01844 347333.

Scriptlines

Xalatan made easier to use

Pharmacia has introduced a new tip to the Xalatan (latanoprost) Eye Drops bottle this week. It is designed to deliver a single drop: some elderly patients found difficulty in ensuring only one drop was administered when using the old design.

For more information:
Pharmacia Ltd
Tel: 01908 661101.

Ethyl chloride fine spray

Cryogesic (ethyl chloride) fine spray aerosol has been introduced by Acorus Therapeutics this week. The aerosol, which is made of steel, is available from wholesalers or direct from Farillon Ltd (tel: 01708 379000). It is available on prescription.

Ethyl chloride is used to test tooth vitality and the extent of regional blockade, to provide transient topical analgesia for surgical procedures, and by physiotherapists to inactivate myofascial trigger points, as part of a spray and stretch technique.

Price: £11.89
Pack size: 100ml
Pip code: 282-7103
Acorus Therapeutics Ltd
Tel: 01338 710505.

Hollister offers alternatives

Hollister has produced a comparison chart for some of the products supplied by SSL's fire-damaged factory (see *C&D, Sep 29, p10*). The charts have been provided in case SSL is unable to supply some of its continence products. SSL International said it has sufficient stock to avoid any supply shortages.

For more information:
Hollister Ltd
Tel: 0800 521392.

Gluten-free range extended

Nutrition Point is extending its Dietary Specialities range of gluten-free products. Part-baked baguettes, long and round rolls and digestive biscuits are available from this week. White and brown loaves will be available from November 1.

Prices: see Price List supplement
Nutrition Point Ltd
Tel: 07041 544044.

Frontshop

Battery is 'always ready' for action

Duracell is introducing a new battery to offer maximum convenience for digital camera users.

Duracell Ultra M3 CR-V3 photo lithium batteries are designed to meet the power demands of the growing number of CR-V3 compatible digital cameras.

The battery offers a clear advantage over AA size rechargeable batteries because it does not lose its charge between uses and is "always ready", even when the camera is idle for extended periods of time.

It does not require the recharging which many consumers perceive as an inconvenience.

Single batteries are packaged in blister cards featuring a digital camera icon and a "for digital" on pack flash.

For more information:
Duracell (UK) Ltd
Tel: 020 8560 1234.

Soothers target radio DJs

Adams is targeting broadcasting professionals with a major sampling campaign for its Halls Soothers this month.

A free limited edition pack of all four Soothers flavours (retail value £2.00) is being sent to almost 2,000 local radio presenters, TV news and sports reporters and other voice professionals.

The packs are being mailed throughout Britain and Ireland in bright yellow jiffy bags. A cue sheet and competition format are also enclosed for local radio DJs who wish to share the free offer with their listeners.

For more information:
Adams
Tel: 02380 620500.

TV next week

Anadin Ultra: All areas

Aquafresh toothbrush: All areas except U, CTV, GMTV, TSW

Aquafresh toothpaste: All areas except U, CTV, GMTV, TSW

Calpol Fast Melts: All areas except U

Clearblue Pregnancy Test: G, A, W

Nicorette: All areas

Nurofen: STV, Y, C, A, HTV, W,M, LWT, CAR, C4, C5, Sat

Oxy: All areas except U, CTV

Panadol: All areas except U, CTV, TSW

Regaine: ITV, C4, C5

PharmaSite for next week: Flu Jab, London – Window, **Zantac** – In-store, **Canesten Oasis** – Dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, C5-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

In brief

Boost for Zinc 48

Mars Confectionery is supporting its Zinc 48 spicy lemon medicated lozenges with a £1.5 million national outdoor advertising campaign. Running in November and January, the campaign will include posters, underground and bus side advertising.

For more information:
Mars Confectionery
Tel: 01753 550055.

Big softie

Beiersdorf is introducing a larger, 300ml pot of Nivea Soft especially for use all over the body (rsp £6.49). The brand is being advertised on TV this month as part of a £2 million campaign.

For more information:
Beiersdorf UK Ltd
Tel: 0121 329 8800.

The beauty is the price

Cork International is promoting its Manicare Velour Puffs with a 50 per cent extra free offer from this month. Three of the soft pink velvet puffs for applying face powder are available for the retail price of £1.49.

For more information:
Cork International
Tel: 0115 978 4271.

Training manual

Periproducts has produced an illustrated training manual to help customers with bad breath. Aimed at medicine counter assistants, the manual is endorsed by the National Pharmaceutical Association. It covers all the possible causes of oral malodour and appropriate OTC treatments.

For more information:
The Miles Group
Tel: 01484 850707.

Out of the blue

Beiersdorf is introducing a male grooming gift pack in its Nivea for Men range for Christmas.

Presented in a metallic blue tin, the pack contains a 100ml Sensitive Aftershave Balm, 150m Double Action Face Wash, a trial size Exfoliating Face Scrub and one Refreshing Wipe (rsp £8.99). Sold individually, the products in the pack are worth £11.

For more information:
Beiersdorf UK Ltd
Tel: 0121 329 8800.

Tutorial No18

Chemist Druggist & Otrivine®

bring you **Treating**

Nasal congestion

THE COLLEGE OF PHARMACY PRACTICE

This tutorial has been designed to meet the requirements of the College of Pharmacy Practice in providing one hour of postgraduate education towards the College's continuing education requirement

Nasal congestion can be a major irritation and interfere with patients' daily lives but is easily treated. There is a range of options available to pharmacists and this tutorial considers how best to tailor treatment to patients' needs.

Objectives

- to understand the physiology of the sinuses
- to appreciate the pathology of nasal congestion
- to be aware of the treatments available for nasal congestion
- to know the indications and contraindications of the various treatments

Nasal congestion is one of the most common symptoms of colds and 'flu. It is sometimes associated with painful congestion in the sinuses. However, this common and uncomfortable symptom is easily treated in the pharmacy.

The paranasal sinuses are air-filled, mucus-lined cavities in the bones of the skull. Although present at birth, they do not properly develop until late in childhood.

Each nostril ends in a cavity that is divided horizontally into three turbinates - scroll-like bony plates cushioned with highly vascularised fleshy tissue. The sinuses are linked to the nose via the channels that drain into the nostrils between the turbinates.

A specialised membrane, the respiratory epithelium, lines the surface of the upper respiratory tract including the sinuses. This membrane produces mucus which protects air passages by trapping dust and other foreign materials. It also has specialised epithelial cells with tiny hairs (cilia) projecting from them. The cilia beat to sweep mucus down into the nasal cavity.

What happens in nasal congestion and sinusitis?

Rhinoviruses are the most common cause of cold symptoms. As these viruses replicate at temperatures slightly lower than core body temperature, they tend to grow well in the nose and conjunctiva but not so well in the lower respiratory tract.

Rhinoviruses infect ciliated epithelial cells in the upper respiratory tract. Infection leads to the characteristic symptoms of a cold. This results from the presence of leukocytes, which cause oedema in the mucosal membranes as the blood vessels dilate allowing fluid to pass through the vessel walls.

This swelling of the sinus lining and turbinates interferes with the normal flow of mucus. Trapped mucus can then fill the sinuses, causing a throbbing pain around the nose and forehead. The blocked sinus can cause a secondary infection (bacterial sinusitis) to develop.

Aims of treatment

Treatment should promote sinus and nasal drainage and ventilation. In turn this should help reduce the risk of subsequent infection. Several treatments can help do this.

- Fluids - increasing fluid intake increases the degree of hydration of mucous membranes, which may already have lost fluid due to fever caused by the cold or flu.
- Steam inhalation - this moisturises membranes in the nasal passages and upper respiratory tract, helping reduce mucus viscosity.
- Volatile compounds such as menthol, benzoin or volatile oils may exert a reflex irritant action on mucosa stimulating some reduction in viscosity, particularly when used topically in drops, spray or with a steam inhalation.
- Saline drops - topical application may help moisturise mucus and improve its flow.
- Antihistamines - their anticholinergic activity, suppressing mucus production in the nasal mucosa, may be of some benefit in allergic rhinitis, but their effectiveness is doubtful in the treatment of the common cold.
- Sympathomimetics - the alpha-adrenergic activity of these compounds causes blood vessels to constrict, reducing oedema, which allows mucus to drain and also allows ventilation.
- Steroids - although useful in allergic conditions, intranasal steroids will be of little benefit in virally caused congestion.
- Zinc and vitamin C - while there is some evidence suggesting zinc may inhibit rhinovirus replication, there is no proof of the efficacy of vitamin C in treating a cold.

Choice of product

Convenience, degree of congestion, frequency of use and length of activity, as well as a consideration of general health status and concurrent medication will affect the choice of therapy.

- While increased fluid intake has few side effects, relief is not instant.
- Steam inhalations, while offering more noticeable relief, may be short-lived and are not convenient to use. Similarly, volatile substances may not necessarily be long acting, or may require the use of an inhalant.
- Saline drops are not long acting, and are unpalatable to some.

Use of sympathomimetics

Sympathomimetics offer perhaps the most convenient relief from congestion, with duration of action anything from between four to eight hours.

Commonly used sympathomimetics include the phenylethylamines:

- pseudoephedrine - taken orally
- phenylpropanolamine - taken orally
- phenylephrine - taken orally or used topically
- ephedrine - taken orally or used topically.

And the imidazolines:

- oxymetazoline
- xylometazoline.

Oral sympathomimetics

Phenylpropanolamine recently received adverse publicity when the United States Food and Drug Administration warned of a possible link between the drug and haemorrhagic stroke. As a result, manufacturers were asked to withdraw

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Nasal congestion

over the counter medicines containing the drug in the US.

The Medicines Control Agency decided that the undesirable cardiac effects were associated with higher doses of phenylpropanolamine than those used in this country and OTC products were not withdrawn in the UK. In spite of this, some manufacturers have withdrawn products as a precaution. Others, such as Novartis Consumer Health, have reformulated products replacing phenylpropanolamine with pseudoephedrine.

Considerations

Although this group of drugs' main activity is on alpha-adrenergic receptors, there is also some activity at beta-adrenergic receptors. There is some indirect activity caused by the release of noradrenaline.

Care should be taken in patients with any of the following:

- diabetes - sympathomimetics may cause an increase in blood glucose levels
- heart or vascular disease, including arrhythmias or atherosclerosis
- hypertension
- hyperthyroidism
- closed angle glaucoma
- insomnia
- prostatic enlargement
- pregnancy or lactation.

Topical administration can help reduce the likelihood of undesirable effects. However, topical sympathomimetic agents can result in rebound congestion if used for prolonged periods. This is due to vasodilation becoming prominent while vasoconstrictor activity diminishes. Hence it is not recommended that topical sympathomimetics be used for more than seven days continuously.

Sympathomimetics will interact with monoamine oxidase inhibitors and are contraindicated in patients taking these drugs. Fourteen days should have elapsed from the patient taking the last dose of MAOI before being allowed a sympathomimetic.

Other drugs that may interact with sympathomimetics include:

- tricyclic antidepressants
- stimulants such as caffeine, amphetamines, methylphenidate
- beta-adrenergic blocking drugs
- digoxin and other cardiac glycosides.

Test your understanding

Test your understanding by answering the following questions, then check your answers by phoning our computerised Telephone Marking Service on **08705 800 287** for an immediate result.

Just listen to the instructions and press buttons 1 or 0 to indicate your answers. "1" indicates true; "0" indicates false. Please note that calls are charged only at standard national call rates.

If you pass and are a pharmacist or an assistant and want the appropriate certificate for this College of Pharmacy Practice accredited course, simply sign then photocopy your answers and send them to: Mary Prebble, Pharmacy Editorial Projects, CMP Information Ltd, Sovereign Way, Tonbridge, Kent TN9 1RW.

Please enter your name and status (eg pharmacist / assistant), pharmacy, address, phone and RPSGB/PSNI number below:

1. Mucus is secreted in the sinuses to help warm the air before it reaches the lung

❑ Yes ❑ No

2. The viruses which commonly cause a cold prefer temperatures slightly lower than core body temperature

❑ Yes ❑ No

3. Congestion is a result of increased mucus volume due to inflammation and localised oedema

❑ Yes ❑ No

4. Improved mucus flow is likely to increase the risk of bacterial infection

❑ Yes ❑ No

5 Antihistamines are likely to dry up congestion caused by rhinovirus infection

❑ Yes ❑ No

6 Over the counter medicines containing phenylpropanolamine have been banned in the UK

❑ Yes ❑ No

7 Pseudoephedrine will stimulate both alpha and beta adrenergic receptors

❑ Yes ❑ No

8 Pseudoephedrine is safe for use by patients who are taking thyroxine

❑ Yes ❑ No

9 Menthol may help stimulate the fluidity of mucus so that it drains more easily

❑ Yes ❑ No

10 Patients using oral decongestants for more than a week are likely to suffer rebound congestion.

❑ Yes ❑ No

How can you toughen up your OTC business? Management consultant John Kerry offers a practical guide

Jason Bennion

Tactically speaking

National multiples are now competing with each other for an increased OTC market share on price, as they do with haircare and other toiletries. They are endeavouring to make buying medicines much more of a routine general shopping decision, rather than a specific purchase at the time of need.

With GSL products available at half price in certain supermarkets this activity will succeed eventually, but it will take some years to change the general public's buying habits.

The market for P medicines, because of the legal restrictions applying to their sale, will be a much harder nut for discounters to crack, particularly if the community pharmacy opposition is geared up to combat price-cutting activity.

The overall impression that discounting multiples wish to project is that all medicines are cheaper in their stores than in smaller community pharmacies.

As has been proved with other categories of non-food products, this tends to be a perception rather than a reality. Pharmacists will be facing varying levels of threat to their OTC business. These threats have to be carefully evaluated and a plan of action devised to effectively counter them.

The principal threats to GSL business will come from:

- national supermarkets
- drugstore chains
- major multiple pharmacy chains.

The threat may be measured by the number of such outlets, and the distance they are from your pharmacy. Any within a minute's walking distance are very high risk. Within five minute's walk or drive – high risk, 10 – 15 minute's drive – medium risk, up to 30 minute's drive – low risk and more than this – very low risk.

With a supermarket, a drugstore and a pharmacy multiple within a stone's throw of your pharmacy, the threat to your OTC trade is clearly very serious and a vigorous protection strategy is called for. A supermarket on the edge of town means aggressive tactics will not be necessary.

Some pharmacies will not have a national multiple competitor within 10 miles and may feel that nothing needs to be done. The threats to your GSL and P medicines trade from national, well organised competitors may very well differ and, likewise, the tactics you adopt.

Service is community pharmacy's major advantage over supermarkets. Pharmacy market shares of fragrances, cosmetics, skincare and to a lesser extent baby care, remain appreciably higher than personal hygiene, dental care, paper products, etc.

Markets requiring a higher level of service and advice will always be more suitable for pharmacy staffed with well-informed, well-trained and helpful counter assistants.

The levels of confidence, product knowledge, technical expertise and helpfulness of both the pharmacist and the staff are the key strengths for the future of any pharmacy's ability to preserve its OTC business. The attitude and skill levels of a pharmacy's staff routinely serving customers and patients need to be evaluated.

Merchandising is something national multiples, whether they are supermarkets, drug stores or pharmacies, are good at. Smaller multiples, groups and independents are generally poor.

Supermarkets and drugstores depend heavily on good merchandising to attract sales. However, OTC medicines are rarely given either the fitment space or attention they deserve in independents, despite the fact that they are the single largest sales category and profit earner.

If OTC medicines contribute 40 per cent of your business they deserve 40 per cent of fitment space. What is the ratio in your pharmacy?

If you only allocate 10-15 per cent of shelf space to OTC medicines, you have a sales to space ratio of about 3:1, which is poor. Allocating 20 per cent of your space gives you a ratio of 2:1, which is average.

Bearing in mind the overall contribution that OTC medicines make towards the profitability of community pharmacy, a ratio of 2:3 would not be wrong.

How skilled are your staff at merchandising? Have they the basic training necessary to help them merchandise the fitments? Are they aware of the importance of brand leaders, TV advertised brands, seasonal promotions, vertical merchandising, hot spots, cold spots, eye level is buy level etc? Assess each staff member's skills separately.

If there is an identified need for staff training in either OTC medicines, dealing with customers,

Continued on page 36

◀ Continued from page 35

sales and promotion or any other aspect of service, this will need to be addressed.

Materials and sources for training are available from the NPA, pharmacy publications, manufacturers, wholesalers, and elsewhere. Alternatively, you may wish to conduct your own regular staff training sessions.

Provide the shelf space to medicines that they deserve and reduce space allocated to low turnover, low profit categories, as it is needed for the more important OTC medicines.

"The window is a prime non-selling area for seasonal displays of medicines"

GSLs need the linear footage on wall and gondola fitments in the front shop. Rarely is the space behind the counter adequate to accommodate all P medicines.

Move the counter to create more "secure" shelf space. P medicines stored out of sight in drawers, that are bigger earners than brands in prime front shop positions, should be visible on the fitments.

Category management will become increasingly important as pressure is exerted by the well organised competition, who make category management pay in their stores. If used effectively, it has a significant effect on brand sales and independents should utilise the science.

Manufacturers and wholesalers provide planograms for all departments within a retail pharmacy including OTC medicines. There is no place for "stack it where it fits" merchandising in a highly competitive retail environment.

OTC medicines, because of their size, do not attract a great deal of attention. P medicines may be six feet from waiting patients.

Manufacturers provide merchandising aids, shelf talkers, "wobblers", display outers and P medicine dispensers. Used prudently, they work by helping to project the brand to the customer.

The window is a prime non-selling area for seasonal displays of medicines. All shelf and counter space is valuable, but small displays help promote product and make an attractive visual break.

Switch selling is where staff are encouraged to suggest that patients may wish to buy an equivalent rather than the requested brand. This would be on the pharmacist's instructions and is useful when developing sales of preferred brands.

Trading up to a larger pack represents savings. When a purchase is converted from GSL to P, it will emphasise a major advantage over the supermarket.

Encourage companion selling: a patient with a cold may only ask for a brand of analgesic. It is always helpful to suggest a decongestant, throat spray, or cough linctus. There are dozens of such opportunities for this method of selling.

EPoS, together with stock control and management systems supplied by wholesalers, have contributed significantly to the efficiency of retail pharmacy. Stock turn ratio and service levels have improved, while wastage has been reduced.

Community pharmacy traditionally carries a little of every medicine that may be demanded by customers, while supermarkets generally do not.

This is a tradition well worth preserving, but it means more profitable medicine stocks should be kept to a workable minimum.

Bulk seasonal bonus offers on medicines can throw stock turn management into confusion. Over-ambitious buying can prove unprofitable if stock has to be carried over to the next season.

Medicines will be successfully sold by pharmacies who exploit their strengths in the future. Service is the supermarket's weakness, just as the ability to sell on price will be that of small independent pharmacies.

For an independent, cutting prices in an attempt to compete with the multiples will expose that pharmacy's weakness.

In certain instances where the competition is fierce, it may be an option to add to the existing strengths, but not to replace them.

Two important activities need to be added to the armoury of an independent attempting to do battle with the multiples on price. They have to buy well to compete on price, and still make a profit.

In this respect, regional buying groups enabling independents to obtain competitive terms may have a big part to play in the future.

Publicity for cut price offers is not just important, it is vital, but it can also be expensive. It is not a case of one or two adverts a year and a few leaflet drops that bring customers flocking to your door.

Supermarkets and pharmacy multiples have established a low price reputation with consistent, hard hitting and expensive campaigns over the past 30 years.

The average symbol group pharmacy may have lower prices than the supermarket or multiple pharmacy, but very few customers will believe them.

No single formula can guarantee an independent will preserve his or her market share in OTC medicines. It would be unrealistic to pretend that the vast majority will not lose some of their sales.

Those independents that play their strong suits well, exploiting their reputation for helpful and professional service coupled with a choice of a complete range of medicines, both GSL and P, will help minimise the erosion of their most important market.

Although few will be able to play the cut price game successfully against the multiples, all can learn how to merchandise and display as well as the best.

Profit calculations

Profit can be expressed in a number of acceptable ways. In the examples below all the calculations are made excluding VAT.

Cash profit

Selling price - cost price = cash profit

An item costing £3.00 and sold for £4.50 would produce a cash profit of £1.50.

Profit on cost

$$\frac{\text{Selling price - cost price}}{\text{Cost price}} \times 100 = \text{profit on cost (per cent)}$$

An item costing £3.00 and sold for £4.50 would produce a 50 per cent profit on cost:

$$\frac{4.50 - 3.00}{3.00} \times 100 = \frac{1.50}{3.00} \times 100 = 50 \text{ per cent profit on cost}$$

Profit on cost is often referred to as the "mark up", which means the percentage goods would be marked up to produce the desired cash profit.

Profit on return

$$\frac{\text{Selling price - cost price}}{\text{Selling price}} \times 100 = \text{profit on return (per cent)}$$

An item costing £3.00 and sold for £4.50 would produce a 33.33 per cent profit on return:

$$\frac{4.50 - 3.00}{4.50} \times 100 = \frac{1.5}{4.5} \times 100 = 33.33 \text{ per cent profit on return}$$

Profit on return is the profit generally quoted by manufacturers.

Charles Gladwin reports on some of the issues which were debated at last week's BPC conference in Glasgow

How genomics could affect you

Developments in genomics and their impact on the understanding of drug pathways could have implications for the providers of medicines in the future.

Medicines data sheets are already including information about the effects of people's gene types expressing certain metabolising or transporting proteins.

If a patient suffers an adverse drug reaction because they are a slow metaboliser and the warning is in the data sheet, would the health professional be responsible, delegates at a session of the Pharmacy Law and Ethics Association were asked.

Further, the development of simple gene test kits, to see if a patient is of a certain gene type which may predispose them to an ADR, is not too far away.

With easy access to test kits, should this sort of information also be included on patient records, asked Dr Paul Debenham, director of LGC, an independent analytical laboratory and developer of chemical and DNA-based analytical systems.

Genomics is now a major factor in the development of new drugs as genetic variations, such as singular nucleotide polymorphisms (or SNPs), can affect drug response. And although a disease may manifest itself with similar symptoms, those may be derived differently in different patients.

In asthma research, for example, a test drug found to be ineffective in 6 per cent of the population was effective in 80 per cent of a particular gene group.

Other areas such as expression of a transport glycoprotein in the intestine could affect uptake of digoxin in 24 per cent of people.

Once in the body, how the drug is metabolised is dependent on pharmacogenetics. If there are several possible metabolic routes dependent on a variety of genes to express different enzymes, one gene type might lack one enzyme with the drug metabolism being shunted down a different pathway.

This could mean that a drug with a low level of active metabolites in one person may cause toxicity in another as certain active metabolites may build up.

Further, ability to metabolise means that the drug profile can be significantly affected. If a gene is expressed too many times, there may be so many enzymes present that a drug could be cleared before it has time to have any effect in the body.

For others, the metabolic clearance may be slowed so that the drug is present for long periods, increasing the risk of an ADR.

All this has implications for people taking medicines. If their gene type is known, then the prescriber or supplier should make sure that the drug is either appropriate, or that a suitable dose is selected, or even if a person has been taking a drug recently.

"The information is there," said Dr Debenham. "So if someone has a serious ADR you could be charged with negligence."

While he acknowledged that some ADRs are due to human error, he believed the impact of genetic variation would be considerable.

And if patients are to be tested for their gene type, where should this be done? Ideally, it should be done before the patient takes the medicine, but to avoid long waits, the test should be carried out in the primary care setting, either by the GP or the pharmacist.

One benefit of genetic research is that it could resolve the problem of postcode prescribing. If tests were developed to show how likely a person was to respond appropriately to a drug it would mean that drugs could be targeted effectively.

On his fourth visit from Down Under, David Campbell (left), past president of the New South Wales Pharmaceutical Council, chats with fellow Aussie Iris Read-Benjamin from Queensland and (relatively) local lad Macdonald Coventry, a Swindon Branch rep on his first visit to the BPC

Jennifer Archer, assistant director of the Centre for Pharmacy Postgraduate Education, has been awarded this year's Synergy Award by the Royal Pharmaceutical Society in recognition of her contribution to pharmacy. Ms Archer has been assistant director at the CPPE since it opened in 1991, previously having worked in the community pharmacy sector

'Glaring need for risk assessment'

Specialist community pharmacy consultants could help improve pharmacy standards by visiting pharmacies to give advice on standards and procedures, a "hot topic" discussion concluded.

Consultants may be able to achieve more than Society inspectors as they would be seen as more neutral. Their expertise could be brought in when needed rather than waiting for the Society inspector's visit once every 18 months to two years.

The discussion followed comments by RPSGB Council member Pat Hoare who raised her concerns about the standards of some pharmacies she sees as a locum pharmacist.

"I see a lot of things on which I could comment, but I could not really make a difference," she said. "There's a glaring need for risk assessment in some of the pharmacies I work in.

"For me, it's difficult as it can be the death knell to your future employment. You may see the positive benefit of reporting things, but I'm paid as a locum. For what I see needs to be done, I would like to be paid as a consultant," she added.

Change is not a choice, it's a reality, said Trevor Jones, director general of the Association of the British Pharmaceutical Industry. Responding to health minister Hazel Blears' address to the BPC banquet, he told the minister that he had noted the number of occasions she had used the phrase "new ways of working".

"I don't know whether that's a threat or a promise," he said. "With electronic transmissions, possibly leading to direct-to-patient delivery, with 500 walk-in centres with state-controlled pharmacies, with acquisition-based generic pricing and a standard fee for dispensing on top, and the uncertainty of what you mean by skill mix, I think we have interesting discussions ahead."

The lads from Safeway gleaning a little clinical knowledge from the ladies of the UK Medicines Information Service. Superintendent pharmacist Paul Bennett (left) and professional development manager Clive Jolliffe with (left to right) Jane West, a medicines information pharmacist at Glasgow Royal Infirmary; Katie Smith, East Anglia medicines information pharmacist, based at Ipswich; and Anne Lee, principal pharmacist, medicines information, Glasgow

Should pharmacists leave the NHS?

Should pharmacists consider leaving the NHS, asked medM director and health economist Dr Darrin Baines.

"The NHS needs pharmacists, but pharmacists don't need the NHS. Most dentists have left, many GPs want to leave, so should pharmacists leave too?" he asked at a tongue-in-cheek but provocative talk at a reception held by MSD.

The pharmacy profession survived for 200 years before the NHS was set up. But pharmacists have been sold the line that they have independent contractor status. "An independent contractor in the NHS is one of the most controlled animals," he argued. The NHS has more control over pharmacists than any other profession, and the NHS makes it less possible for pharmacists to survive change.

"Leaving the NHS might be the only way pharmacy can survive the turbulent times ahead. Have you seen an unhappy dentist? Dentists left the NHS because of a change in the NHS contract. Dentists found that fee-for-service payments were not always profitable."

PMS were introduced to pacify the better-paid GPs, he said. "The lesson from GPs is that 'the more you pay us the more rebellious we will be'. That's the opposite of pharmacists. If I were a pharmacist I would have a GP as my main negotiator as every time they negotiate change, their income goes up 20 per cent."

Further, consultants refused to be part of the NHS unless they could have a private income.

Some would argue that pharmacists are trapped by the dispensing fee. They provide knowledge but are paid for activity, he said.

Now that RPM has gone, just one more change may tip the scales. So pharmacists should consider leaving if the dispensing fee changes, or if drug reimbursement at cost is introduced. Or if local contracts are changed, or if LPS become compulsory.

Pharmacists could become private service providers, he suggested. "Pharmacists should bid to provide local services under LPS as private providers and not as NHS bodies.

"Pharmacies should be therapy centres. They should introduce charges for individual patients. Every patient who visits a pharmacy should pay £5, £10 or £25. Pharmacists should also arrange themselves into chambers like barristers.

"Pharmacists should talk to colleagues and devise business plans for non-NHS activities and make local and national promotions."

Having provoked the audience so that they hissed and booed but also showed their agreement, Dr Baines concluded: "I believe that pharmacists should not leave the NHS as pharmacists are the foundation of the NHS. Like all foundations, you do not notice they are there until they subside. If pharmacists remove themselves from the NHS, I do not think the NHS will recover.

Instead, he advised: "I would begin negotiations by saying pharmacists want to leave the NHS. Threatening to leave the NHS may leave you in a stronger bargaining position."

Dr Darrin Baines, right, with father Lloyd Baines, left, and Dr Terry Maguire, who is soon to stand down from his post as director of the Centre for Pharmacy Postgraduate Education and Training in Northern Ireland

Joint training is the key

Community pharmacists' relationships with other health professionals could be improved by joint training, said delegates at the British Pharmaceutical Conference.

In a session called *Confidence and Competence in the Future*, pharmacists were asked a series of questions relating to the delivery of pharmaceutical care.

Other suggestions for improving relationships included:

- creating a need for the services pharmacists can provide
- focusing on the patient as a way of making contact with other health professionals
- raising awareness of the concept and terminology of pharmaceutical care with other professionals.

Better co-ordination of services needed

Better co-ordination of healthcare services could save thousands more cancer patients' lives, Professor David Kerr, University Hospital Birmingham NHS Trust, said. And pharmacy should be brought more fully into the English cancer strategy, he added.

Cancer mortality rates in the UK are almost 50 per cent worse than the USA and some European neighbours, but the rates could be improved if there were better links between primary and secondary services

The lower rates in the US are in part due to earlier detection and diagnosis of cancers, as more doctors and nurses are employed in cancer care there, he said.

There is also a problem with funding. "Often funding in the NHS is arbitrary. He who shouts loudest wins, rather than he who provides the most logical case," he said, although this attitude is starting to change.

Professor David Kerr: "There's a problem with funding"

Picking up on Dr Harry Burns' theme of improving prevention, he said: "It seems a desperately important thing to me, but we throw threepenny ha'penny at it.

"We have not been able to reach out in a strong or logical way to the community, or the GP, or the community pharmacist, because most of the drive for improving cancer services is through people like me, so there has been a focus on secondary services.

"There is some money coming in, though, for example, to support and pay for GPs to have an educative role in the community. Pharmacists should be clustered around that too.

"There must be pharmaceutical input into improving treatment," he continued. "It seems ludicrous that pharmacists are not more involved. You should be lobbying to be more involved," he told delegates. "Pharmacy needs to play a role and be part of establishing specialist teams."

Dr Kerr approved, though, of the Scottish cancer strategy, described to him by Dr Norman Lannigan, as having pharmacy "written all over it".

"It's crazy that we do not have your level of pharmacy representation on our board [in England]," he told Dr Lannigan.

New Code shows shift of emphasis

The new Code of Ethics differs significantly from the old one by looking beyond the profession to service users and purchasers, Helen Darracott, from the RPSGB's professional regulation directorate, said.

"The approach of the new Code is to recognise that pharmacists have the autonomy to make their own decisions. It expects pharmacists to be accountable for the decisions they make, it identifies the key responsibilities underpinning professional practice, and it encourages pharmacists to use their own professional judgement," she said.

"This is probably the biggest change.

"The new Code is a tool to promote good practice, to prevent poor practice and to intervene in unacceptable practice."

Mrs Darracott hoped that the new Code would also provide the starting point for implementing clinical governance within the profession, particularly within community pharmacy.

Concentrate on health risk prevention

Tackling risk prevention could be more cost effective for healthcare in the long term than simply treating ill-health once it arises.

But to shift the emphasis of spending will require better co-ordination of health and social care, Dr Harry Burns, director of public health for Greater Glasgow Health Board, warned.

Instead of patients apparently having a convoluted journey between various healthcare professionals and social care services, Dr Burns said it would be far better if the system could be better co-ordinated.

"This calls for a new way of thinking of NHS management," he said. At the moment, the NHS management is like a baby sitter, trying to get people to stop doing "bad" things, and to encourage them to do "good" things.

At present, that focus is on the "babies" or clinicians within the service. The NHS has to turn this focus round, by bringing together the resources for the "audience" or patients. The focus should not be on the individual institutions, but on smoothing the patient's pathways between the institutions.

RPSGB president Marshall Davies (left) and Dr Harry Burns, director of public health for Greater Glasgow Health Board

Dr Burns highlighted the problems of funding for public health by referring to smoking cessation schemes. Investing in such services, where the benefits will not be seen for many years, means that the investment can be an act of faith, he said.

Sharing the fruits of collaboration

Pharmacists who had taken part in a collaborative course between England and Scotland shared their experience with others at the BPC.

In a joint initiative between the Centre for Pharmacy Postgraduate Education and the Scottish Centre for Post Qualification Pharmaceutical Education, 20 pharmacists from both countries undertook a course in community pharmaceutical care development last autumn.

The aim of the course was to develop local community pharmacist leaders who were able to share with colleagues their experiences of:

- delivering pharmaceutical care to particular patients
- developing their practice to target the skills and activities of the pharmacist towards patient care
- co-operating and integrating with the primary healthcare team.

After the course, which lasted for five days, the pharmacists were set two assignments. The first was to work with an individual patient on medicines management.

The second was to discuss with local healthcare professionals possible ideas for pharmaceutical care. There was a dedicated discussion board set up on the CPPE website for delegates afterwards. The pharmacists used this for exchanging ideas and felt it was a valuable tool for removing the isolation they felt when they returned to their practice. Delegates met up again in the spring to discuss their progress.

Anna Marie McGregor, from Abbey Chemist in Glasgow, said the course was an opportunity to network and share experiences with like-minded people. "It was directed towards your individual learning and challenging your way of thinking about things."

After the course, she said the website discussion forum was useful for seeing what other people had tried and whether it had worked or not.

Elizabeth Read (left), BUPA superintendent, Hannah Rees of BMI Healthcare and Pam Calvert of Harrogate Healthcare Trust at Saturday night's welcome evening

GPs still have reservations

A qualitative study involving 14 medical practices, 42 health professionals and 14 patients has found that doctors still have reservations about the nature of community pharmacy.

The study, carried out by Sharon Simpson-Prentis, a nurse PhD student at the School of Healthcare Studies, University of Leeds, found that issues raised by pharmacists hinged on professional relationships.

The perception of patients interviewed by Ms Simpson-Prentis was that pharmacists had time for older people. The continuity of care that might be offered by independent pharmacies was also flagged up.

Lack of resources often hinder professional co-operation, and accountability causes concern, especially among GPs, who often do not appreciate that they may share liability with pharmacists.

Have your say!

What was the biggest issue affecting you during 2001? Did you feel you had enough help from your professional organisations, or from your suppliers, when the going got tough?

community pharmacy

If you have a message you would like to send to your suppliers, or to the great and the good at the Royal Pharmaceutical Society, National Pharmaceutical Association or the Pharmaceutical Services Negotiating Committee, then this is your chance to have your say in Community Pharmacy magazine, C&D's sister monthly title.

In our December issue, we are looking to poll community pharmacists' opinions on the people, the issues and the products that made (or didn't make!) your year.

Send back the completed coupon, by October 26, and you could also be in with a chance to win £25 in book vouchers.

Which, of the RPSGB, NPA or PSNC, do you feel has most effectively represented your interests during 2001?

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7. Does he guide you on how to increase your profits?	❑	❑
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9. Does he have contacts in the pharmaceutical industry with stock takers, EPOS providers, shop fitters, purchase/sale agents, and specialist finance providers?	❑	❑
10. Is your top rate of tax 20%? If not, why not? Are you therefore paying 40%?	❑	❑
11. Has he reduced your tax liability by 50% annually by restructuring your business. Average tax savings would be about £8,000 p.a.	❑	❑
12. Has he suggested the possibility of setting up a personal or company pension scheme (SIPPS or SSASs)? This would enable you to get tax relief and allow you to purchase commercial properties in your pension fund, without having to pay capital gains tax	❑	❑
13. Can he set up employee benefit trusts, allowing you to obtain a full tax deduction for payments made e.g. payments of £50,000 can reduce your tax liablility by about £10,000	❑	❑
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15. Has he set up offshore companies and trusts that allow you to accumulate vast amounts of wealth totally tax-free?	❑	❑
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17. Does he plan for the future sale of your business? The worst scenario should be a 10% tax liability, the best is no tax liability.	❑	❑
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Chemist & Druggist's web site – *www.dotpharmacy.co.uk* – has introduced a service that offers pharmacists free legal advice from a leading solicitors' firm.

The service – dotLaw – is being run with the co-operation of Charles Russell, whose specialist legal fields include pharmacy matters.

Pharmacists are advised to e-mail their questions to – *pharmlaw@ubmint.com* – along with their full name and the name of their pharmacy. The latter two details are for *C&D*'s records only – pharmacists' identities will be kept anonymous when the answers are published.

All the questions and Charles Russell's replies, which will be available in two working days, will appear on a new dotPharmacy page called dotLaw.

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All in a day's work

A serious look at the things that really mattered at this year's BPC...

It is a sorry state of affairs when PCT chief executives start telling pharmacy jokes – and at a pharmaceutical conference, too. Makes you wonder what they say when they talk to other health professionals about us chaps!

North Peterborough PCT's head honcho, Chris Town, raised more than a titter when he trotted out this little number at the BPC though. It was obviously something his audience could identify with.

"What is top of the Christmas list for community pharmacists this year?" he asked.

"A video celebrating 50 years of the NHS, specially adapted to run backwards so that it has a happy ending."

BBC presenter John Waite also attempted to introduce a little levity into his consumer perspective on the pharmaceutical industry.

There is only one product which came into the world without any problems, he suggested, and it is a famous American invention, dairified emulsion paint that comes in a can.

"Carnation Milk is the best in the land,
Here I sit with a can in my hand,
No tits to pull, no hay to hitch,
You just punch a hole in the son of a bitch."

Complaints about the standard of verse should be made to *You and Yours*, Radio 4.

You can tell from this brief resumé of conference highlights that the content was as relevant to community pharmacy practice as ever. And that was without a pixie from the Scottish Health Department putting us all in the pixeel!

Certainly the conference venue had that suburban feel that will be familiar to people who work in the heart of their communities. Those who walked from the conference hotels (under the motorway, over the pedestrian flyover, past the vacant lots and the wannabe casino) were unsurprised to see chalk marks on the pavement outlining a body.

There were moments to treasure, though. For starters, there was that suave Council member Sid Dijani accosting the taxi driver who delivered Prof James McElnay in the mistaken belief that he was Clive Jackson from the NPC.

James 'The Prof' McElnay, from Belfast, making a hasty getaway from Sid Dijani and his "friend"

Angela Alexander limbers up for a bout of leg wrestling with Peter Ballard

There was the expression on health minister Hazel Blears' face as ABPI director Trevor Jones went through a selection of slightly blue but definitely non-PC jokes. It was a shame one member of the top table seemed to have a little problem with his eyelid muscles.

Then there was the morning after with Irn Bru drowning hangovers as a speaker – a local lassie – rested against the podium, took a sharp intake of breath, blanched a little and then carried on with a homily to pharmacy and the good work of NHS Scotland.

Angela Alexander, that most responsible chairman of the CPP, flexed thighs with Peter Ballard of Genus Pharmaceuticals in a leg wrestling contest. He claimed to have been standing in for NPA director John D'Arcy.

Having the police SWOT team sweeping through the Conference Centre checking for bombs in advance of the Princess Royal's arrival prompted the comment that it was a sign of the times that the police no longer look younger, but wear bullet proof vests instead.

Dr Terry Maguire, of the NICPPET, Queen's University of Belfast, struggled with an identity crisis since his name badge described him as Mr Maguire from the NI Centre for Pharmacy, Robert Gordon University.

Name badges were also a problem for Asda superintendent pharmacist John Evans. They were sponsored by Tesco and he objected to sporting the enemy's colours.

Following Tuesday evening's Ceilidh, two members of the PSNC were understood to be in serious negotiation with the DoH (Department of Hangovers).

So it was good to get back into the office on Thursday, Septemb 27, after the BPC. The first bit o post to land on the desk was a letter from Pauline Nicklin, conference bookings, confirming our registration details.

"Final details will be sent to yo closer to the conference date," it concluded. We look forward to receiving them.

Finally, two questions to pond Who might be having elocution lessons? And who might be said t have "striking buttocks?"

Turn up at BPC in Mancheste next year to find out.

John Evans, Asda superintendent in defensive posture

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